



Psychopathology *and* Atmospheres

Neither Inside nor Outside

Edited by

Gianni Francesetti and Tonino Griffero

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FOREWORD

TEACHING ATMOSPHERES

GIOVANNI STANGHELLINI

In the last decade, the formation of clinical phenomenologists has become a *must* for many distinguished academics. For about one century our catalogue has been tremendously rich in essays, but remarkably poor in handbooks. Even the cornerstone of our canon, Jaspers' *General Psychopathology*, originally written as a textbook, can hardly be given to a student as a basic reading. This makes teaching the fundamentals of our discipline extremely difficult.

Given the *Zeitgeist* and its praise for manualization, relevant efforts have been made to manualize phenomenological knowledge, both in philosophy and in the clinics. Relevant examples are Dan Zahavi's *The Oxford Handbook of Contemporary Phenomenology*, *The Oxford Handbook of the History of Phenomenology* and *Phenomenology—The Basics* (Routledge, 2018). Also, in 2019 the *Oxford Handbook of Phenomenological Psychopathology* will finally come to light.

Students ask for manualized knowledge, and that is a fact. Undergraduates and postgraduates expect teachers to teach them a kind of knowledge that is indeed a *know-how-what-exactly-must-be-done-in-a-given-circumstance*. Manualized therapy has become synonymous with evidence-based therapy, and obviously vice-versa: what cannot be translated into a standard procedure that can be easily taught, learned and applied, is unscientific. CBT specialists are obviously the champions of this game.

All learning is based on a process of recognition. And teaching, indeed, is first and foremost teaching on how to recognize someone or something. "Recognition" means at least two things. The first and more obvious meaning is to attribute a singularity to a category as a member of this category—*identification* of a thing or person from previous encounters or knowledge. This is what happens in standard education. In clinical training this process is called "diagnosis" and diagnostic skills are deemed a

fundamental part of the agenda. And students are spot-on when soliciting this kind of knowledge to be regimented and normalized.

Yet “recognition” has a second meaning: *acknowledging* the absolute singularity and individuality of what or who is out there. To recognize someone or something means to be able to tolerate the *otherness* of someone or something. This kind of recognition is a practice in which epistemology is in touch with ethics. This second kind of “recognition” is obviously in conflict with the former. Whereas recognition *qua* identification or *diagnosis* is an act of recollection or remembrance based on previously acquired knowledge, recognition *qua* *acknowledgement* is an ethical act of acceptance of the unique being-so of the other person or state of affairs.

Here comes the importance of atmospheres: since it is so difficult to pin down atmospheres in terms of recognition *qua* diagnosis, to reduce them to operationalized formulas, then the capacity to recognize atmospheres, the sensibility to “smell” that something is going on, is based on the “negative capacity” to tolerate that what is going on is not easily reducible to a precise cognitive category. This practice opens up a kind of educational agenda—or perhaps we should talk of formation or *Bildung*—that is totally different from the one required for teaching recognition *qua* diagnosis/identification.

Atmospheres are a key chapter in an ideal Handbook or Course in clinical phenomenology. The reason is not *just* that trainees should learn how to recognize the atmosphere’s significance in the clinical encounter, as taught by Tellenbach and Minkowski, and become able to use their knowledge to diagnose the kind of atmosphere that envelops a given patient or encounter. Atmospheres are there to be acknowledged and respected *as such*, and not mechanically reduced to the logic of the *gnosis* moment of knowledge.

Atmospheres can help us (teachers and students) to depart from the logic of recognition *qua* identification and its tacit metaphysics (entailing Self-World distinction) and implicit epistemology (entailing the need to translate *pathos* into *logos*). Atmospheres belong to the pathic moment of experience, the moment when Self and World are merged. The pathic transformations impressed by atmospheres are not directly accessible by ordinary language, not to mention to the technical language of descriptive psychopathology. They can only be indirectly made sense of by a process that is metaphoric in nature. This process brings experience to the reflexive realm, but will perpetually remain unfinished. Metaphors do not pin down atmospheres, on the contrary they enhance atmospheres, amplifying them and enchainning other metaphors.

There is another reason why atmospheres must be part of the residents' *Bildung* agenda. There is a kind of knowledge that cannot simply be taught—it *must be learned*. What I mean is that there exists a kind of formation in which the student must *engage*. Learning the atmospheric dimension of clinical practice is similar to learning how to swim: it requires being available to immerse oneself into atmospheres. One can hardly learn how to swim studying manuals or listening to swimming classes. A student can learn the importance of atmospheres if and only if she makes herself available to engage into it. This "engagement" is, to a certain extent, not different from an act of faith.

The issue of formation is haunted by a more general issue; that of trans-generational transmission of knowledge. The contemporary trend to manualized knowledge is, at least in part, the consequence of the misunderstanding of mentor/disciple relationship. The disciple is responsible to learn at least as much as the mentor is responsible to teach. Teaching is not just transmitting an algorithm for diagnosis or treatment, but *embodying* an attitude, a method. The disciple must, in their own turn, do their best to embody what they have learned from their mentor. Learning is not just memorizing and reproducing a piece of knowledge, but *appropriating* it. Appropriating implies being *responsible* for what one has learned and for the way one applies it.

This process is not simply based on cognition. Something more atmospheric is at play: the *influence* of the mentor upon the disciple in the process of formation. In an age where technical skills are emphasized, teaching itself can be misunderstood as a technical performance rather than as a human encounter in which the teacher as a person is in the foreground. This has long been considered a cornerstone in the field of arts, but scientific institutions seem to be tardy to acknowledge the importance—in the positive as well as in the negative—of the personal contact between mentor and pupil. From this personal encounter emanates an atmosphere which may inspire both. Within this inspiring atmosphere an institution may become a seat of learning, research and knowledge, a place in which principles of thought and conduct can be established, instilled and transmitted from generation to generation.

INTRODUCTION

GIANNI FRANCESETTI AND TONINO GRIFFERO

We often say that “there is something in the air” or that “there is something brewing”, that we feel, who knows why, like “a fish out of water” or “at home”. It goes without saying that by expressing this “something-more” of a certain situation we do indeed refer to “atmospheres”, to something that is clearly felt even though we cannot define and explain it.

But why do we use this term? The term comes from the Greek (ἀτμός, “vapour”, and σφαῖρα, “sphere”) and in meteorology denotes the gas envelope surrounding a planet. Although its use has been metaphorical since the 18th century along with some forerunners (*aura*, *Stimmung*, *genius loci*, *ambiance*), it has boomed only recently in the Humanities. In fact, bypassing positivist conventions and endorsing more spatial and affective paradigms, rather than temporal and cognitive ones, they focus more on the vague and expressive *qualia* of reality (the how) than on its defined and quantified materiality (the what), more on the “how” we perceive (pathic moment) than on “what” we perceive (gnostic moment).

Never wholly detached from its climatic meaning of immersion in the weather-world, “atmosphere” is a colloquial term meaning a “something more” and deeply depending on the context. “Atmosphere”, indeed, works sometimes as a neutrally descriptive expression of a situation (person’s or room’s atmosphere), or implicitly as an axiological term (by exclaiming “what an atmosphere!” we usually express *ipso facto* a favourable condition) and other times it needs instead qualifying adjectives (there are tense, relaxed, gloomy atmospheres, etc.). This semantic ambiguity is obviously also conditioned by the kind of expectations of the persons involved in the situation. Saying, for example, of a political summit in which high hopes are placed that it produced a cordial atmosphere we are probably stating its failure. An atmosphere can therefore, paradoxically, be everything and nothing: something increasing the quality of life or characterising the merely superficial decorative value of a thing or situation.

In any case, in today’s debate, atmosphere is no longer meant as a decorative aspect of life, but rather as a feeling or affect that, being not

private and internal but spatially spread out, “tinges” the situation in which the perceiver happens to be and affectively involves them. In its recent theoretical sense, the notion was independently introduced in the 1960’s by psychiatrist Hubertus Tellenbach and philosopher Hermann Schmitz.

Tellenbach conceives of atmosphere as an elusive but essential quality of intersubjectivity, especially generated through olfaction and taste. If positive, it gives the new-born the necessary trust for a correct development of her personality. From a different point of view, the oral atmosphere provides the psychiatrist with an effective diagnostic tool for psychic diseases whose symptom is indeed a loss or deterioration of olfaction.

Schmitz, on the basis of a wide and challenging anti-reductionistic (new) phenomenology of the felt body (*Leib*), considers feelings as atmospheres, thus restoring the Homeric concept of feelings as demons poured out into a non-localizable space that preceded the age of introjection (from Plato onwards). Therefore, atmospheres are not subjective moods, as internal psychic states projected outside, but affective powers that exist discontinuously as quasi-things and that authoritatively fill a certain surfaceless spatial situation. Thanks to felt-bodily qualities common to both perceived forms and perceivers (suggestions of movement, synaesthetic qualities), in principle atmospheres can be experienced by anyone, regardless of whether the single perceiver merely notes them or is so deeply involved in them that they are assured of their personal identity through these absolute “subjective facts”.

Being philosophically interesting, not despite but precisely because of this vagueness, an atmosphere does not coincide, however, with an exclusively subjective *nuance*. In fact, Humanities have been pleasantly stirred by the radical externalisation of the affective suggested by the neo-phenomenological approach. What followed was a promising paradigm shift, whose main merit is a counterintuitive yet inspiring campaign of desubjectification of feelings. A neophenomenological atmospherology, in fact, problematically (of course) downgrades the psyche to a superfluous as well as theoretically unproven artificial construct encompassing a private ineffable inner world (be it the soul, the psyche or, especially today, the brain), considering this view of the emotional life hardly more realistic than the Greek archaic one, conceived of as the state of being possessed and driven by demonic powers.

The notion of atmosphere, however, finds its full humanistic legitimacy only later thanks to the philosopher Gernot Böhme (from 1990’s on). Highlighting the sociocultural factors underestimated by Schmitz, Böhme places atmosphere at the centre of an aesthetics understood as a general

theory of perception (intended neither as information processing nor as a distal recognition, but as an affective experience of the perceiver). Partly following neophenomenological externalism (atmospheres are something out there), he sees atmosphere as a tuned space and even as the primary step of perception: the in-between where environmental qualities (object) and human bodily feelings (subject) meet and that is responsible for our feeling well or not. Whereas, according to Schmitz, the intentional creation of atmospheres is something impossible or only results in “impressive situations” for manipulative (propagandistic or advertising) purposes, Böhme recognizes that an atmosphere is nothing without a person feeling it and conceives of staged atmospheres both as the main goal of what he calls “aesthetic work” and as the key issue of the late capitalist “aesthetic economy”.

Böhme’s more detailed approach to phenomena and the atmosphere they radiate through various generators (movement impressions, synaesthesia, scenes, social characters, ecstasies of things, etc.) paves the way to explaining the successful career of atmospheres outside philosophy. If atmospheres are involved wherever something is being staged, they are almost everywhere, especially in all activities that today are aimed at giving things a given appearance or look. Since probably no situation is totally deprived of an atmospheric charge, it follows that not only do we continuously speak of atmospheres and take this way of talking for granted, but we are also accustomed to being able to describe them and verify their influence on actions, sometimes even on events of historical and collective significance.

Thus normalized by Böhme, the notion of “atmosphere” appears to be perfectly at home in most—if not all—scientific fields that have to do with human and not strictly measurable behaviours and habits. The notion could improve an innovative heuristic approach in all the research areas that are not “medusized” by an exclusively thingly orientation and by strictly functional parameters. Not only aesthetic professions in the strict sense (architecture, interior design, light design, art, sound engineering, scene painting, music, social work, advertising, marketing research, politics, perfume making, nursing, human resource management, psychotherapy, etc.) but all human activities are therefore somehow influenced in their lived space by atmospheric feelings.

In short, one could say that whenever there is greater emphasis on felt-bodily experience than meanings, on emotionally arranging an environment than narratively representing something, on appreciating phenomenic nuances than quantifying phenomena in order to statistically predict future events and thus avoid any involuntary life experience, the

atmospheric approach appears to be ever more necessary, regardless of whether atmospheres are freely floating objective powers (Schmitz's idea), "only" the outcome of the subject and object co-presence (Böhme's idea) or even in some cases a qualitative-affective "colour" idiosyncratically and unconsciously projected by the perceiver on the outside.

The discussion of atmosphere today covers a wide range of hardly separable theoretical and applied issues. Philosophy has generally understood atmosphere more as a sensory-affective engagement with the world than as a perceptually limited object, giving particular attention to the ontological vagueness, the predualistic and quasi-thingly nature of atmospheres, taking the latter as the key elements of a general pathic aesthetics, or focusing on the suddenly perceived intertwining of environment and feeling as the real subject of promising research fields. Apart from studies more directly related to media and arts and the large-scale research on *ambiances* and urban life, it must be pointed out that the humanities today use the notion of atmosphere in an ever increasing number of fields such as (first of all) architecture and human geography (which is not surprising given the common focus on spatial *qualia*), but also design, pedagogy, psychotherapy, psychiatry, marketing, politics, sociology, ecological and social anthropology—in short, in every study that, as already mentioned, problematizes the producibility and management of effective individual or collective emotional states.

Among the disciplines interested and potentially stimulated, or even shaken, by an atmospherological paradigm there are certainly the psycho-approaches. The concept of "affective tuned space" is challenging both the paradigm of a mono-personal mind and of a bi-personal mind. The first considers the affective experience as an inner state, more or less influenced by external stimuli, the second considers it as the emerging phenomenon of a co-creative process resulting from the mutual interactions of two individuals. An atmospheric paradigm implies something more, even though it is not alternative and can contain the above two approaches.

From this perspective, the affective experience is emerging neither inside the person, nor outside, or between therapist and patient, but with—or even before—them. Here, the relationship precedes the *relatees*¹ (so to speak). It is an invitation to look into the processes of the emergence of subjectivities and world, to the pre-dualistic, undifferentiated and synaesthetic dimension of the experience. It is the *pathic* from where we are moved, to which we are subject. This dimension is clearly crucial to all psychopathological explorations not heavily and restrictively biased by an individualistic reductionism. This focus can contribute to the emergence

¹ From Latin *relata*, those who are in relation.

and to the development of a new paradigm in psychopathology and in clinical work: a field based clinical practice. The field perspective has been widely explored and used in some psychotherapeutic approaches, in particular in Gestalt therapy—that has included the situation and the field as cornerstones of its epistemology and practice—and in psychoanalysis. But a *field turn* really affecting the psy- disciplines—as the *relational turn* has done in the last decades—has yet to come.

The perspective presented here is an invitation to a journey beyond the ‘tragic necessity of dualism’ (as Fachinelli would say), an exploration towards the infinite opening from where the experience comes, towards the stranger knocking at our door, towards a radical understanding of what “creature” means: the ongoing and unceasing process of being created. The contributions to this book don’t start from a common ground, since this has yet to be created: indeed, this is the first book specifically addressing this topic. It is more a ground-breaking adventure, challenging a reductionist and largely unsatisfactory approach based on a technical, pharmaceutical, symptomatic, individualistic perspective.

The enterprise of building a common ground that considers atmospheres—and so the situation and the field—as essential elements in order to understand and care for clinical suffering is just beginning and in progress. This book is aiming to contribute to this development, since to focus on atmospheres in psychopathology, in clinical practice and in psychotherapy, is a way of including the “something more” that resists being reduced to the individual, to the naive natural attitude and even to the paradigm of co-creation. We hope that the stimuli presented here can contribute to the development of a radical relational perspective on clinical human suffering and its metamorphosis in therapy, also continuing to encourage and promote the debate and exchange of ideas between psy- and humanistic approaches.

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CHAPTER ONE

THE INVASION OF FELT-BODILY
ATMOSPHERES:
BETWEEN PATHIC AESTHETICS
AND PSYCHOPATHOLOGY

TONINO GRIFFERO

1. An atmospheric psychotherapy (without the psyche)?

Not only can “being” be expressed in many ways (as Aristotle claims) but ‘atmosphere’ can, too. However, what I want to discuss here is not how many variants of atmospheric feelings there are, but whether “the power to appreciate atmospheres” may really “disclose territories of psychopathological understanding that would otherwise remain off-limits” (Costa et al. 2014, 351). Without going into my own atmospherological project (Griffero 2014a), the ontology of quasi-things on which it relies (Griffero 2017) and the pathic aesthetics that makes up their context (Griffero 2016a), suffice it to say that atmospheres are inter-subjective and holistic feelings poured out into a certain (lived) environment. As a real affective in-between, an atmospheric feeling precedes any analytic activity and influences the emotional situation of the perceiver from the outset, also resisting—at least in its ideal-typical case¹—any conscious attempt at projective adaptation and amendment. Its pervasive and influential “presence”, linked to felt-

¹ Elsewhere I have focused on the atmosphere’s specific power (Griffero 2014b) and, depending on the degree of objectivity-externality and the type of resulting emotional “game”, I have distinguished (Griffero 2014a, 144; 2017, XIV, 28) between: 1) prototypic atmospheres (objective, external and unintentional, and sometimes lacking a precise name), 2) derivative ones (objective, external but intentionally produced and always arising from the relationship between perceiver and objects) and 3) even quite spurious ones in their mere relatedness (subjective and even projective).

bodily processes acting as its sounding board and characterised in its affective affordances (Griffero 2014d) by a qualitative microgranularity inaccessible to a naturalistic-epistemic (third-person) perspective, must be considered a “spatial” state of the world rather than a very private psychic state (Griffero 2014c). Saying, for example, that one is overwhelmed by anger or sadness, envy or shame, is therefore real and not merely metaphorical,² since one is taken by the real authority of these atmospheric feelings, which influence our life’s meanings, goals and priorities pre-reflexively, normally in a synaesthetic way, and exactly through the modes in which our felt-body is attuned to the outside.

By dealing with the psychopathological meaning of atmospheres (see also Paduanello 2015-2016) I’m of course straying into a minefield. After abandoning my disciplinary ship, I am constantly at risk of moving like a (philosophical) bull in a (psychological) china shop. Despite all groping around in search of an unknown elsewhere is both a strategic investment in the chances given by a dialogue without corporative borders and a concrete application of the “competence in compensating for incompetence” (Marquard 1989, 22-37) in which philosophy often takes refuge, somehow trying to protect the millenary idea of philosophy as expertise about the condition of totality. The fact that so far all the efforts made to unify psychology have failed further mitigates the sensation that my naive reflections should be guilty of some lese-majesty crime.

The issue here is that atmospheres as quasi-thingly phenomena sometimes make us ill and other times fix and heal us instead. They can often have no effect at all but, under certain conditions, they can also be toxic or benign and even therapeutic, particularly if the person, who is passively and felt-bodily immersed in atmospheres, is also actively engaged in their production through their action and inaction. The atmospheric dimension is therefore essential for anyone who is not satisfied with a psychotherapy that blindly apes physiological-pharmacological medicine and naturalistic experimentation, which notoriously assumes that every reality, including the suffering person’s, is nothing but a constellation of measurable parameters (here symptoms) and is increasingly desensualized-disembodied so as to do without sensory perceptions and sensible environments.³ Entirely focusing on an anatomical explanation of subjectivity disorders, a naturalistic approach especially underestimates the role of psychotherapeutic perception as abandonment to the perceived, preferring

² This would fatally remove atmospheres from science and force them just into a literary exile.

³ Including, of course, the patient’s environment external to the setting (Huppertz 2003, 194-195).

to conceive this perception either as a mere objective reaction to a stimulus or as a too subjective interpretation of it. A “good” psychotherapy should rather consist both of a careful description of the “how” of a self-showing suffering and of an interpretation of its clinical symptoms (Holzhey-Kunz 2014) in their undeniable deviation when compared to “normality” (but with a low level of causalism and deferral to something else at the expense of the given). But it must especially avoid thinking that, on the sole ground that a certain methodology exists and works in the most acute cases, then it must also be applied to less serious ones (and only on the basis of the researches carried out in the last three years). Moreover, since people in mental distress—whose cognition, perception and ego-structures deficits (also on the linguistic-semantic level) are somewhat counterbalanced by the highest level of felt-bodily experience—are probably the most vulnerable subjects to atmospheric effects, it is in no way surprising that a close link between atmospheres and psychotherapy could be established here. For the same reason, it should be expected that paying attention (theoretically but also practically) to atmospheres may be an essential component of the societal approach to the health of some of its psychologically disturbed members.⁴

However, I cannot hide the fact that atmospherology is only a chapter of a larger neo-phenomenological project that aims at challenging every (biological, neurological or physical) reductionism and naturalisation, at better understanding the actual and spontaneous life experiences⁵ that we normally describe in terms of conscious self-reflection, self-awareness and first-person perspective (“how one feels in her environment”), and even at finding a better way of living. In fact, due to the modern monotheism of reason one no longer knows what to do with this kind of reason, cleansed as it is of every trace of what is involuntarily touching and affectively binding. And all this holds true to the point of inducing to use the most diverse individual or collective methods of elation or to daze in order to reduce one’s own sense of self-insecurity. A reductionist approach, in fact, culpably underestimates the “what is it like” of a lived phenomenon and makes of it nothing but an epiphenomenon, thus mistaking (due to a categorical error) the graphs of the mere physiological brain activity for real feelings and moods. Perhaps this approach ultimately explains why one feels something physically, but not why one feels what one feels

⁴ Paying attention (theoretically but also practically) to atmospheres could be for society a specific approach to the health of some of its psychologically disturbed members (Sonntag 2013, 308).

⁵ See also Küchenhoff (2013, 51).

emotionally,⁶ that is, what it is like to experience this specific *Erlebnis* in the first-person perspective⁷ (the only thing that is at stake here). From a neo-phenomenological point of view, the philosophical approach as such is already suggested by some dysfunction of the normal flow of life, by “perplexity” (Stoerring 1987) or “loss of natural self-evidence” (Blankenburg 1971)—in short, by the deep personal disturbance of the process of finding oneself (*Beirrung*). Therefore, it deals with painful borderline situations trying to avoid understanding the traditional “know your situation” as the holistically hypnotical “stay inside the lines”.

For this very specific neo-phenomenological empiricism,⁸ the millenary prejudice by which philosophy as *vita* eminently *contemplativa* completely disregards affective and bodily involvements should be dismissed. For this, New Phenomenology, more than other philosophical currents, naturally lends itself to an application to psychopathological disorders, no doubt reflecting, *qua* philosophy, on atmospheric pre-reflective feelings but not looking for the causes of a disease (genetic level) more than required by a descriptive stance. Metaphorically put, the (new) phenomenologist does not examine the situation by looking at the geographical map to decide their next intervention, but aims at a deep landscape-experience (Langewitz 2008, 136). Understood (from my point of view), as an (aesthesiological) philosophy based on a mix of activity and passivity, the trick of new phenomenology is to locate itself at the “right distance to allow the emergence of an atmosphere” (Costa et al. 2014, 354).⁹ For this and other reasons atmospheres and psychopathology display a deep elective affinity.

Although it is also widely acknowledged that New Phenomenology could have useful psychotherapeutic applications as a humanist approach based on an interactive conversation (Janssen 2008, 71, 74), there is a great hurdle that needs to be overcome. In fact, just as it focuses on bodily phenomena without relying on the physical body, this orientation¹⁰ also

⁶ Kügler (2012, 236, 239).

⁷ See Nagel (1986) and, for a description of *Erlebnisse* as a fully scientific approach, Gadenne (2008).

⁸ That makes it possible, as will be outlined below, to assess our more or less successful felt-bodily harmonizing of the different personal aspects in which inside and outside are not separated yet (Blankenburg 1995, 197-198), and possibly also to step out of ourselves by turning to the other one (Moldzio 2008, 165).

⁹ This right distance and aesthetic attitude (predisposition), despite resulting from Kantian disinterestedness, is instead exactly what my pathic aesthetics criticises (Griffero 2016a, 19-41).

¹⁰ Schmitz sometimes also expresses his interest in Freud's therapy (but not in his metapsychology, considered guilty of introjectionism, associationism, singularism

does without the psyche, by substituting it with the concept of personal world and externalised feelings. As a “psychiatry understood as a subjective medicine without soul” (Schmitz 2015, 78), New Phenomenology downgrades the psyche to a superfluous as well as theoretically unproven artificial construct encompassing a private ineffable inner world (be it the soul, the psyche or, especially today, the brain). It considers this view of the emotional life (Schmitz 1989, 96) hardly more realistic than what the Greeks before the fifth century B.C. conceived as being driven by the gods, who actively interfered with human lives. In this alleged interiority, Western culture (from Democritus and Plato onwards) has exiled everything that by vagueness or complexity falls under the *reductionist razor*—i.e. both external feelings and felt-bodily emotions—imagining the psyche as a box or a container under human control: if you will as a house consisting of several floors, made up of impulses, perceptions, representations, etc. And yet it has never realized (since Plato’s *Sophist* 263e) that the person, under illusion of being exonerated from the diktat of involuntary affects, would therefore be both the inhabitant of this house and the house itself.

This ambitious challenging of Western intellectual prejudices, against the idea of the introjection of affects and feelings—thus separated both from the body and from the world (Fuchs 2013, 612)—is obviously a fly in the ointment of psychotherapy to the extent that it denies precisely what the very term “psychotherapy” implies. This also holds for dualistic psychosomatics, which would do better to rather examine the relationship between physical and lived body and between felt body and environment (Schmitz 2010, 219). To optimistically talk about “prosopiatry” (Jacob 2013, 175-176) or an ideal-typical approach to individual cases (Werhahn 2011, 95-97) and not about psychology is nothing but a stopgap solution. Instead, a better option is the view by which what we call physical and psychic diseases—that is, the entire experience of world-as-opportunity—is solely due, as we will see more clearly later, to a disintegration or stiffness of the felt-bodily dynamics. It can be then argued from the outset that a therapy focused on atmospheres, so to speak, translates the psychogenic dimension into a felt-bodily and situational one and turns the therapeutic triangle of therapist-patient-situation (Stoffels 2005, 178) into the therapist-patient-atmosphere one. In the latter, the atmosphere, far from being an operationalisable therapy phase, is for me the convincing proof that neither man as such nor his/her environment alone are responsible for psychic disorders.

and of a multilayered conception of psyche) and especially in the more dynamicist Jung (Schmitz 2005, 102-103).

“Atmosphere” can therefore be defined in many ways, also in psychotherapy. More specifically, it refers to the scenario from which the patient’s phenomena (partly) originate (pathogenesis), the tool and the skill that will enable the therapist to understand the disease (diagnosis), the therapeutic process inasmuch as it leads the patient to open up and resolve his/her emotional impasses (setting), and finally the healing process as a functional emotional regulation. All these stages are atmospheric or, at least, atmosphere-conditioned events. Trying to simplify, however, I will schematically and chronologically distinguish between three distinct phases.

2. Just Before

A) The setting

It is necessary to go beyond Frank’s therapy criteria (1972) and provisionally say that a good atmospheric setting, based on a healthy milieu with an antipsychotic effect—even only fifty minutes per week!—, implies a number of factors. I certainly do not mean paradoxical situations like the successful therapy resulting from periodical and absolutely silent meetings, depicted by Bela Grunberger and convolutedly interpreted by Sloterdijk as the scenic equivalent of the foetal night,¹¹ but the much more “classical” therapeutic setup. The idea that atmospheres could be intentionally produced is still somewhat philosophically controversial—also because it is suspected that an intentional staging of a spatial feeling inhibits its effects or may end up being a vehicle of a dangerous psychic hygiene (Bollnow 1941, 133) or, at least, of a manipulating propagandistic “technique of impression” (Schmitz 1998, 181-182). However, I prefer to recognize that a certain atmospheric effect, though perhaps not the already mentioned prototypical one, can sometimes be planned, as shown by many so-called atmosphere-jobs (Böhme 2001). I do not only mean architects, interior designers, light designers, artists, sound engineers, scene painters, musicians, social workers, advertising executives, marketing researchers, politicians, perfume makers, nurses, human resource managers, etc., but also teachers, nurses, employees in customer contact, physicians,¹² and

¹¹ During which “no more of him [the therapist] remains in the space than a sponge, absorbing the patient’s silence and nourishing it with its counter-silence” (Sloterdijk 2011, 354).

¹² At least, those who admit the felt bodily dimension alongside the physical one and seek to harmonise the medicine system and the patient’s world in some non over-intellectualised way.

especially psychotherapists and psychiatrists. To put it very briefly, like contemporary art, largely based more on atmospherically arranging an environment than on narratively representing something, the clinical encounter should also create the therapeutically “right” atmosphere.

A good setting must probably rely on a space that is not excessively decentralized and radiating normality in order also to avoid, as far as possible, the usual social stigmatization of almost every “psy”. Without being sensorially sterile or too clinical (furnished in a plain, cosy style, with soft lights, soft colours, etc.), the setting should prevent pathological influences, given that also a poor sense-stimulating perception, for example a routine-like experience, can find a strong felt-bodily resonance, not least an anxyolytic effect, especially in an injured felt-body. As in the “best” hospital facilities, where it has long been known that patients recover more quickly thanks to design and good siting decisions, for example if they have a view of trees and nature from their windows (Ulrich 1984), the patient should feel welcomed and safe throughout the setting, so that they may come in with openness and less fear (Lorenz and Penzel 2007, 56), being forced to experience something intentionally unusual only in the most serious cases.¹³

Nevertheless, or perhaps because of this normality, accessing the setting acts as a “transition to another space”, freed from the anxiety-provoking outside world and so different from the latter as to allow the patient to feel it in a new and slightly unexpected atmospheric way. It is worth pointing out, in this respect, that it is exactly the most important (prototypical) atmospheres that we perceive in transitions, thanks to the so-called ingressive moment. Therefore, even entrance halls and lobbies should not be underestimated, because—as architects know—a well designed facade (in the broad sense) triggers a very deep first impression that is hard to correct later and from which indeed one can sense the moods that can take place within its framework. As a special case of milieu therapy (in the broad sense) entirely relying on a very intermediate-transitional space (Winnicott) between therapist and patient, a good (or bad) atmospherization also reflects the setting’s lived space, duly de-medicalized but not devoid of authoritative scientific competence, including also certain things that are capable, for whatsoever reason, to ecstatically radiate this or that feeling. In other words, the setting should develop a process of “negotiating the intimacy” (Helferich 2007, 233) between the two protagonists whose timing is crucial for successful

¹³ For example a “soft room” (spacious, bright, relaxing colours) providing a controlled regression through a low-stimulus environment (Hofmann 2007, 28-30).

treatment. The ultimate aim is therefore a good balance between openness and closeness.¹⁴

B) The first impression

But the “before”, obviously, does not only concern the “material” setting. In fact, right from the very first contact, the specific domain of psychotherapy is a situation based on a good or bad felt-bodily communication. It is a reasonable assumption, for example, that the therapist may initially give a felt-bodily priority to his/her patient,¹⁵ giving the latter time to better explain their situation. So the therapist may get a first virtual image of the patient, which may even induce them to decide whether or not they feel able to work with this patient (Marx 2002, 239). Thanks to this first mutual incorporation, made possible by the therapist’s good intuitions and a tactful attitude¹⁶ to establish a better balanced interpersonal felt-bodily dynamic, they should then phenomenologically dodge the intention of assessing objectively classified symptoms and accept (in a sense) a certain dullness or chaotic multiplicity in the pathological personal situation,¹⁷ here neo-phenomenologically understood not as a distinguished character but as “a viscous mass in which countless masses glide and which glides in countless such masses that are all situations” (Schmitz 2008, 32).

This global, immediate but non-quantifiable impression is precisely an atmospheric situational perception, an experience of “how” rather than “what” the patient feels, limited as far as possible in its logocentric approach. One might mention here, obviously, the well-known schizophrenic “*praecox feeling*” (Rümke), but also the presentiment of mania, hysteria and even of borderline disorders (Moldzio 2002, 262). All these first-contact impressions result (van den Berg 1955) from symptomatically

¹⁴ Open doors (in many respects) often have a positive impact on the patient’s state of mind.

¹⁵ The therapist can thus avoid the usual and annoying “split between professional and private thinking (‘as a doctor I must tell you...; but as a man I understand that you...’)” (Burger 2008, 147).

¹⁶ Saying that “atmospheres are haptically experienced” (Costa et al. 2014, 356) and that “tact is the capacity to feel the atmospheric and to attune with it” (Stanghellini 2017, 111) only has a metaphorical value, since atmospheres are rather the outcome of synaesthetic experiences (Griffero 2014a, 63-69, 113-119).

¹⁷ According to Schmitz, this multiplicity, forming a possibly latent part of a personal situation in friction with the others, better explains the unconscious without assuming a Freudian multi-layered psychic “geology” (Schmitz 2005, 105-106).

informative things like a weak handshake, the gaze, the walk, uncertain movements, a gap between the therapist and the back of the patient's chair, fingers tapping on the armrest, or even the first telephone contact (Marx 2005, 233): in short, from what a gesture-based interaction can reveal of the patient's biography, their lifestyle or being-in-the-world (Kraus 1991, 104). Concrete help also comes from the phonosymbolic and only apparent metaphorical value of words used by the patient to refer to some abnormal phenomena. Despite being totally untranslatable and unintelligible outside of the therapy framework, these words bring a mostly tacit realm into the slightly more reflexive-linguistic one,¹⁸ at least during therapy, and thus act as co-generators of the overall atmosphere.

C) The right questions

A good atmospherisation of the setting must also include the type of questions posed by the therapist. Whereas closed questions generate single facts and thus take for granted the constellationist approach of natural sciences to objective facts, open questions instead seem to be the most appropriate way to ensure that patients express their "subjective facts" in a narrative (and maybe also atmospheric) way, without too quickly submitting themselves to the traditional doctor-patient role model (Langewitz 2008, 129-130). Instead of constellationally reducing the patient to a mere network of single data, as such in principle reconstructable and manipulable, the therapist should pay attention to the tacit knowledge highlighted by a situational approach and be interested above all in dimensions like wholeness, meaningfulness (or relevance) and internal diffusion. As a master of atmospheres or impressive situations, which they should "sense" in the patient and in which they can submerge without abducting them too logically, they should look, if you will, more like Maigret than Sherlock Holmes (Großheim 2010). It entirely depends on what general psychological theory one adopts, whether the specific atmospherisation "sensed" by the therapist has to be considered as a symptom that necessarily refers to a universal illness, or rather as a

¹⁸ I agree that the clinical encounter is "an event suspended between the pathic and the linguistic domains of experience" (Costa et al. 2104, 356) and that language has atmospherical power, but I reject the frequent temptation of conceiving atmospheres as metaphors and linguistic creations rather than real facts (in the sense of felt-bodily ones). Something that like the prototypical atmospheric feeling is untranslatable into a parallel literal sphere cannot be said to be metaphorical (Griffero 2014a, 112).

phenomenon indicating an individual's changed being-in-the-world (Kraus 2005, 68).

3. During

A) Atmospheric diagnosis

When it comes to the diagnostic role of atmospheres and to the predisposition to clinically receive atmospheres, Jaspers seems to still be the guiding point. He writes that when "the environment is somehow different, not to a gross degree, perception is unaltered in itself but there is some change which envelops everything with a subtle, pervasive and strangely uncertain light. A living room which formerly was felt as neutral or friendly now becomes dominated by some indefinable atmosphere" (1962, 98), he is exactly describing a "space with an atmosphere" (Binswanger), i.e. charged with a special mood-like significance.¹⁹ In other words, the therapist experiences a specific affective meaning that is spatially poured out. To a certain extent, they also share with the patient the "for-me-ness" characterising every atmospheric feeling. Despite being typically unable to precisely determine that meaning (Sass and Pienkos 2013, 142), they actually comprehend the affective alterations "vividly enough as an exaggeration or diminution of known phenomena" (Jaspers 1962, 578). It is wrong to radically disregard the analysis of a more biology-oriented psychiatrist (not to be confused with a more reductionist neuroscientist), namely the disorder's underlying mechanisms, and entirely deny that a good pluralistic psychopathology should take into account both the living experience of the felt body and the measurable dimension of the physical body.²⁰ Nevertheless, it is clear that the organic is just the material precondition upon which the atmosphere supervenes. The therapist, as we have seen, atmospherically anticipates the disorder through their first impression, well knowing that a situational and not only pathogenic atmosphere, as Thure von Uexküll's situational-circle, does not coincide with what is consciously and reflectively experienced, primarily because it involves, among other things, a much more stratified background that even

¹⁹ "Suddenly the landscape was removed from me by a strange power. In my mind's eye I thought I saw below the pale blue evening sky a black sky of horrible intensity. Everything became limitless, engulfing... I knew that the autumn landscape was pervaded by a second space, so fine, so invisible, though it was dark, empty, and ghastly" (Jaspers 1962, 82).

²⁰ For such a balanced position, which leaves open the question of the effective link between mental and physic, see Töpfer (2007) and Dreitzel (1982, 65).

includes the unlived life and the imaginative dimension (Schmidt-Degenhard 1995).

As expected, an atmospheric approach means paying attention to the patient's environment, having a sense of their affective "situation" (Fischer 2005, 41) even before trying to effectively manage the therapeutic climate. The first issue that needs to be addressed here is the therapeutic boundary between atmospheres and moods, i.e. feelings differently radiated by the environment each time, and more durable and stable existential feelings that are felt less distinctly and often conflict with the atmosphere encountered (Fuchs 2013, 617). But for me it is more likely that existential feelings (moods), atmospheres and emotions, far from being ontologically different states, should constitute a continuum in everyday life: indeed it is not unusual that an occasional atmosphere becomes so "objective" and pervasive that it is transformed into a less transient mood, or vice-versa that a stable mood becomes so subjective, temporary and even intentional as to downgrade to a single and thing-based emotion²¹ or a thingly ecstasy (in Böhme's terms). It may happen, in fact, that a diffused atmospheric feeling condenses itself into things and/or persons that become, therefore, its centre of irradiation without being its cause (or anchorage point, to agree with Schmitz). The fact that the atmospheric fear of a visit to the dentist, for example, does not direct itself towards the real cause (the pain as anchorage point) but can rather spread a negative aura on the dentist as a person, the tools they use and even the gossip magazines in the waiting room (condensation area), explains very well that the intentional (or formal) object of a feeling, always assumed by orthodox phenomenology, is often just something apparent.

Now, despite being focused on the pre-dualistic²² (pervasive) quality both of atmospheres and moods—on their being neither inside nor outside, just like the air we breathe (Fuchs 2008, 95)—the diagnostic attention should still be able to separate what is pathologically most important and durable (atmospheric existential feelings) from what is not (the single temporary emotions, usually directed towards specific objects). Actually, the former constitute "a background sense of belonging to the world and a sense of reality" (Ratcliffe 2008, 39) and structure the way one finds oneself in the world as a "basso continuo". Even if they obviously "often

²¹ Fuchs (2013, 619) admits this, at least in part, by saying that "moods are strongly influenced by surrounding atmospheres" and that a mood tends to elicit corresponding emotions.

²² Even the term "related" (to the world) seems misleading for an atmospheric feeling, where there is no subjective experience of a mere individual self, separated from the enveloping global atmosphere (Kimura 2005, 115).

remain unnoticed, because they manifest themselves primarily in the way the world and the others appear to the patient" (Fuchs 2013, 616), they predetermine every single directed and surface emotion. In this (now altered) background or lived space the patient walks like an anxious child in the forest (Berner 1991), experiencing a feeling that lacks any precise "aboutness" and that, for this very reason, without ebbing and flowing like the single emotions, is unfortunately taken for granted.

The first and probably most important contribution to understanding the atmosphere as a diagnostic tool is surely due to Tellenbach's book (1968) on the non-rational, prejudicial (in the positive sense), intrinsically emotional-fusional and powerfully mnemonic (and therefore also atmospheric) oral sensorium. If all humans (even all organic beings) emanate and smell feelings through odours, the therapist should have a good and immediate nose for the imponderable atmosphere of others, for that inexplicit "surplus" that in the best case acts as a protective and trust-based sphere and in the worst case instead works as a protest against every atmospheric attunement. Consistency between a keen eye or nose and the atmospheric radiance is thus, for Tellenbach (1968, 62-63), the very medium of intersubjectivity and consequently the most important component of any understanding process. Especially the delusional mood or atmosphere, understood as the limited time of a critical transition from an atmosphere to another and as the feeling (perplexity and de-realization) that precisely precedes or accompanies the development of schizophrenic delusions, can and must be precisely diagnosed and assessed as the original phenomenon (an atmospheric clouding) (Tellenbach 1968, 111) of a real pathological (ineluctable) atmosphere. Tellenbach then explores some pathological pre-psychotic *Erlebnisse* of the oral sense, from the less serious disorders (decrease in taste and smell intensity) to the much more severe ones (receptive disorders), in which "the atmospheric can no longer affectively pervade the individual" (Tellenbach 1968, 127), resulting in a loss of smell receptivity (*Entstimmung*) or a despondency caused by one's own (alleged) bad smell (*Verstimmung*). Despite focusing on the abnormal atmospheric effect of olfactory hallucinations, he does not tell us much about how to detect this "downfall of the freedom in an atmospheric overpowering" (Tellenbach 1968, 161). But the diagnostic specification of the link between a certain detected atmosphere and a certain disease, of course, does not fall under my sphere of competence.

B) Atmospheric therapy

My question is very straightforward: how is it possible to treat pervasive atmospheres that nobody is able to willingly perform in order to make of them healing? This challenge first and foremost involves acknowledging that the task of every healthcare professional largely consists in “detecting moods as well as withstanding moods, controlling moods and above all designing moods” (Könemann 2007, 44). For this to happen, an atmospheric therapy, based on a lived intercorporeal performance rather than a cognitive-linguistic relationship, must not wage war on the disease as an enemy²³ but should aim to strengthen the patient’s healthy parts (Emrich 2012, 211-212). For this reason, it appears implausible that therapy should “begin by showing the patient that his way of being-in-the-world has acquired a pervasive colouring” (Dreyfus 1989, 6), by explicitly exploring the events, cognitive formations and the course of the patient’s background schemas²⁴ in order to lead them to experience life the way it was before it became one-dimensional (Becerra 2004, 5, 3). If it is indeed true that maladaptive and dysfunctional atmospheres are probably formed during the early stages of the individual’s development, it seems however extremely doubtful that their now solid felt-bodily, pervasive-affective and extra-linguistic colour could be changed by intentionally and cognitively “constructing more adaptive schemas via accessing and re-processing trauma-related beliefs” (Becerra 2004, 7). Delusional atmospheric beliefs, being by no means propositional attitudes to take an unreal thing to be real but rather ways of being in the world (Ratcliffe 2010), are impervious to counter-arguments and propositional revision (acting as a meta-mood), even if they inevitably have also an impact upon reasoning—albeit only in the gestaltic way in which the background influences a figure (Schottenloher 2010, 212 ff.).

It is obviously tempting to assume that the best therapy should be an almost-hermeneutical “fusion of horizons”, where the therapist becomes part of what is happening and thus greatly contributes to the atmosphere that dynamically bears the back and forth of dialogue (Reuster 2005, 73). This happens especially in psychodramatic therapy, seen as a (felt-bodily, among other things) warming up²⁵ to the symptom that allows the patient, thanks also to a real “feeling into one another”, to feel and change his/her

²³ See, for example, Antonovsky’s idea of salutogenesis.

²⁴ This argument is based on the very dubious premise that “atmosphere” could be understood as a precursor of what a cognitive schema is for behavioural therapy.

²⁵ It can be brought closer to the Schmitzean “being sucked into an acting atmosphere” (Schmitz 1980b, 54).

affective involvement within a comprehensive (atmospheric) emotional field (Frick 2005, 98-99). But by defining therapy as an “in-between” prior to the emergence and distinction of subject and object and therefore as the only true therapeutically productive “first atmospheric impression”, one is inclined to think of the relational perspective (based on the emergence of the contact-boundary) in the phenomenological field as conceived by Gestalt therapy, which seems one of the best candidates for a consistent therapeutic application of the atmosphere. More precisely (Francesetti 2015, 6-12), this approach shifts the therapeutic focus from the patient to the ephemeral and dynamic. Within the latter, the therapist turns the suffering into an absence situated at this contact-boundary, which is co-created and co-actualised by the therapist’s²⁶ and the patient’s presence in the here and now. Therefore, Gestalt therapy is fully entitled to consider the patient’s depression as an always situationally different depressive field, a momentary feeling of getting depressed together that, as a quasi-thing or ecstasy of that specific situation, the therapist is able to transform (not strategically, however) by making absence into presence.²⁷ Now, whatever the chosen route, it presupposes both the patient’s complete trust and the therapist’s relevant competence-understood, contrary to Freud’s first model of an unemotional surgeon, as a being-with without hierarchy and hospital roles differentiation. My view is that this empathetic (but not intrusive) and communicative (but not only linguistic) capacity to create a friendly climate (Marx 2008, 184; 2013, 140 ff.) is just a part of an organisational approach based on the therapist’s ability to also distance themselves from this interplay, without that meaning a fully rationally designed situation, since it is well known that an excessive affective planning has often the opposite effect to the one intended.

But on this level therapeutic approaches will naturally differ, depending on how the disorder is conceptualized (as inhibited feelings, pending history, unconscious psychic inner conflicts, etc.), and I lack the necessary competence to go into detail about it. I will only repeat that the therapeutic setting’s atmosphere, developing the ubiquitous in-between in a targeted manner,²⁸ comes from a mutual encounter and is substantiated by more than a million bodily signals (Sonntag 2013, 127), resulting in a

²⁶ The therapist would thus work primarily on their presence-absence dialectic and their bodily presence.

²⁷ But is it really worth defining the emerging pain as a form of beauty (as does Francesetti 2015, 15, 12)?

²⁸ It is worth recalling that for Kimura the “In-Between” is both horizontal (between man and his environment and between other men) and vertical (between single life and life itself through prolepsis and anamnesis).

widespread atmosphere of intimacy (Stanghellini 2017, 179) that enables the patient to open up to the therapist—the only person to whom they confess something secret (something shameful, guilt-driven or traumatic). This way the therapist is able to detect their *trouble générateur* (Minkowski) and to help them, especially in instances of schizophrenia, and to emerge from their (too) private world into a sort of extended self (Kimura 2007, 254-258). It is very likely that, both as an implicit background and as a problematic figure, this interpersonal but pre-dualistic in-between (*aida* in Japanese: see Kimura 2013, 108 ff.), will only work if it has been preceded (also in the therapist) by an intrapersonal in-between and a kind of *arché-aida* (prior to the self/other distinction), whose deficit—for Kimura the non-meeting with own absolute otherness may cause the non-meeting with the patient's otherness—would lead to the lack of naturalness and, finally, also to schizophrenia.

C) Neo-phenomenological suggestions

But all of this already lies outside my area of expertise and I should rather address a more limited issue: that is, what Schmitz's New Phenomenology, which first gave dignity to the concept of atmosphere, can suggest in terms of its therapeutic application. Without going into detail and obviously without the competence to judge if his suggestions are appropriate or valid from a therapeutic point of view (please, don't shoot the messenger!), I have to mention at least two key points. The first is the central role of subjective facts, which we must protect and which we should return to. The person knows indeed *what* they are thanks to the objective self-attribution of subjective facts, but they know *who* they are only thanks to a regression to a primitive presence²⁹ (also called focusing), which only

²⁹ The person as a conscious subject with the capability of self-ascription can always go back to this proto-identitary life (given as identical to us without identification and reflection thanks to "primitive present/presence", in both a temporal and a spatial sense), by means of the vital drive and felt-bodily affective involvement. Self-ascription, by which identity is normally explained, is actually only possible (unless one wants to end up in a *regressus ad infinitum*) if it is based on self-consciousness without identification: that is, if I am already acquainted with myself. Of course, this primitive present/presence as a guarantee of the coincidence between identity and subjectivity, and fusion point of five elements that cannot yet be distinguished (here, now, being, this and I) at this point can and must also have a development. What is later produced is an unfolded present/presence (the world): a condition that is emancipated from life (also by means of sentential speech) in the primitive present/presence, in which, as we have seen, all meanings are still subjective for someone.

guarantees their full subjectivity and self-awareness (Schmitz 2002, 209), provided that feeling good means to continuously fluctuate between personal and pre-personal subjectivity,³⁰ and that many psychological disturbances are (Schmitz 1965, 255-281) related to the bad relationship between emancipation and regression. The second key point is that the non-anatomical bodiliness, properly experienced only by the person who “inhabits” it, constantly generates intercorporeal superordinate units in the pericorporeal space in the form of incorporation or excorporation (felt-bodily communication). Hence a wide range of possible states, some positive (prevailing expansion) and some negative (prevailing contraction), according to the shape of the intertwining between the two extreme poles of the whole vital dynamic,³¹ namely “narrowness” (contraction) and “vastness” (expansion) (*Enge / Weite*).³²

The first therapeutic application of these principles is that therapist and patient (from the first image the therapist gets of them) (Marx 2008, 183-184) give birth to an ad-hoc felt-bodily unit based both on mutual incorporation and on the cooperation of expansion and contraction.³³ It is hard to understand whether the therapist is thus obliged to establish with the patient a unidirectional and addiction-like felt-bodily communication. However, it is clear that the therapist is unlike the surgeon, who needs to taxonomically categorize what they are working on and not to be influenced by atmospheres. Rather, the therapist deals with multiple biomedical unexplained symptoms and chronic diseases, which neither happen in the precise way that brings from the diagnosis to the restoration of health, nor are explicable through a simple causal link, and can be treated without the patient’s active involvement (Burger 2008); therefore, they must initially let the symptoms happen. In other words, the therapist must allow their own felt body (Langewitz 2013, 194-199) to become a precise and diagnostically effective sounding board of the atmospheres that the patient rejects despite latently suffering from them. Thus, the vague atmospheric background that is skilfully generated by the therapist and aimed at the patient’s symbiotic-regressive phase should also

³⁰ This necessary regression may sometimes initially even exacerbate some symptoms, just as too much common ground between the partners may hinder the therapeutic efforts.

³¹ It is worth noting from the start that this dynamic, unlike the Freudian drive, is non-objective and afinalistic.

³² Its extreme points are terror and therefore impotence (in contraction) and sleep and therefore unconsciousness (but also orgasm) in expansion.

³³ “It is obvious that these processes of embodied interaffectivity as well as their disturbances are of major importance for psychiatry, in particular for all kinds of psychotherapeutic interaction” (Fuchs 2013, 626).

influence the figure, that is, the patient's discrete abnormal emotions and their felt-bodily resonance. The therapist can then even ask the patient which felt-bodily isle³⁴ is concretising their feeling³⁵ in every case, without losing sight of two issues. The first one is that, since well-being usually means noticing nothing about one's body (except in the cases of desentitization), a felt-bodily thematisation always implies the risk of awakening something that could otherwise remain pathologically inactive.³⁶ The second one is that there may be a gap between the here and now feelings elicited in the patient by their own narrative, and the feelings that were experienced when the trauma occurred and that are the therapist's real focus. That said, let's now look at three types of disorder that Schmitz reviews in his writings³⁷ on the basis of a certainly very controversial approach (perhaps a too causalistic one) of which I merely give a synthesis here.

1) Problems of the felt-bodily dynamics—resulting from the contraction/expansion intertwining and binding form³⁸ and able to influence the personal vital drive, the stimulus-openness and its directability³⁹—would cause borderline personalities, posttraumatic stress disorders and endogenous depressions. An anomalous rhythmic oscillation indeed determines insensitivity⁴⁰ (weak sharpness of impulse selectivity as in hyperactivity, mania), eating disorders,⁴¹ contradictory dialogue

³⁴ Hence a point of contact, worthy of further investigation, with Genellin's key concept of "felt sense" (Croome 2008).

³⁵ Perhaps also by a free musical improvisation, which allows him/her to try something new in a trusting and relaxed atmosphere (Holzheimer 2005, 278).

³⁶ Only "when the body is rendered opaque through loss of function, we become aware of it as alien presence", that is, of "the hegemony of an occupying force" (Leder 1990, 82).

³⁷ For a first attempt at a psychotherapeutic application of Schmitz's three points (primitive presence, biographical dimension and personal world/alien world) see Marx (2002, 239-249).

³⁸ That should be neither too loose nor too compact but capable of a balanced vibration in order to avoid that the drive becomes congested, resulting in conflict zones.

³⁹ Turning one's own body (and the physical) into a vicarious partner and/or abnormal regenerating the fragile connection between contraction and expansion may, for example, lead to self-harming behaviours (Moldzio 2002).

⁴⁰ The person becomes "a rock in the waves of feelings" (Schmitz 2010, 217; see also Schmitz 1980a, 327).

⁴¹ Anorexia is not a disorder of the body image but, due to an imbalance between narrowness and vastness, an involuntary felt-bodily, contractive (epicritic) and shameful reaction to felt-bodily (and partly physical) expansive (protopathic) changes of the body as well as, of course, to social, cultural and historical

between contraction and expansion (pain), disorganisation (independence) of felt-bodily isles (hypochondria).⁴²

2) Disorders of the inbetweenness within the personal situation, especially of the non-guaranteed fluid oscillation between personal emancipation and personal regression, are responsible for various diseases. Schizophrenia and its initially threatening atmosphere results precisely from a loss of elasticity and homeostatic balancing between these two poles. Instead, just to mention some variants, an hypertrophy of the personal world makes the patient, in their affective vulnerability, unable to neutrally-objectively explicate the internally spread meaningfulness of a situation (hence the reduction of impressions and ideas to quasi-things, with a hyperconcretism of the metaphorical); alternatively, the loss of mineness may hinder their affective involvement⁴³ (Moldzio 2005, 193ff.). Hysteria (split personality) would be caused by an uncontrollable fluctuation of the two poles; melancholia by an excessive or insufficient stimulus-reactions; instability, addiction, panic and primitivism instead by the predominance of one of the poles in the form of a one-sided incorporation; lastly depersonalization, derealization and eccentricity by, respectively, a too strongly separated (privative) stress, the absence of stress and the atrophy of personal regression (Schmitz 2002, 193, 199, especially 1980a, 415-473).

3) Finally, there are personal disorders. These (maybe wrongly labelled as neuroses) consist of abnormal frictions that take place in the usually smooth placement of partial situations within the personal situation,⁴⁴ which act not only retrospectively (as required by psychoanalysis), but also presentively and prospectively,⁴⁵ or in personal difficulties in dealing

(therefore atmospheric too) dimensions (Marcinski 2017). Obesity should be linked to the "revenge" of the protopathic on the over-epicriticity and bulimia to the incorporating fascination with what one rejects.

⁴² Which can be re-balanced also by gently brushing the skin (Schmitz 2010, 231-232), as happens especially in the case of dementia-sufferers (Sonntag 2013).

⁴³ By the term "schizophrenic flat affect" one refers both to a diminished affective expression and to an affective experience. Because of this loss of affordances, especially in the most serious Cotard's syndrome, one can feel "surrounded by a multitude of meaningless details" (Sass 1992, 50). For a first approach to the application of Schmitz's alphabet of felt body economy to kinesthetic schizophrenia see Schmoll 1995).

⁴⁴ The personal situation is not an asyuhun for the soul but rather a very demanding partner for the person (Schmitz 2015, 90-91).

⁴⁵ It should be noted that forgetfulness (new-phenomenologically redefined as implication) is by no means a disease, but rather a necessary presupposition of new

with programs and problems as part of a situation. Other disorders (anancasm, sensitivity, compulsive disorders) are due to the anomalous delimitation between the personal idiosyncratic world and the personal alien world,⁴⁶ to the lack of grey zones mixing subjective meanings and neutral ones, etc. Lastly, it should also be added that for Schmitz the Western history of splitting the world into external vs. internal is a long-lasting collective illness (Griffero 2016a, 134-147).⁴⁷

Therefore, a neo-phenomenology-based atmospheric therapy probably should: a) restore the correct “competitive” felt-bodily dynamics, possibly even through the right distance (between the patient on the couch and the analyst behind them) that is however in its own way a form of felt-bodily communication, even if based on a partial excorporation of the therapist; b) ensure the fluid oscillation between (personal) emancipation and regression; c) re-balance the interconnection between different levels of the personal situation. The list of strategies provided by Schmitz for this purpose includes linguistic influence, massages, muscle relaxation, autogenic training, yoga, suggestion and even hypnosis, breathing, relaxation and meditation techniques, felt-bodily integrating gymnastics, general forms of incorporation (more or less reciprocal), and even table tennis (!) with its healthy rhythmic components!⁴⁸ In all of this, unfortunately, the role of atmospheres is not sufficiently clear, not to mention the validity of what could now (but not when Schmitz wrote!) be considered a “New-Age” style approach. After translating psychotherapy into “therapy of subjectivity”, Schmitz (2002, 198) does not go beyond the call for leaving the patient free to expand⁴⁹ and setting in motion the process of change and consolidation again,⁵⁰ of expanding the sphere of allowing-oneself-to-be-touched (Schmitz 1989, 98-102) and encouraging the vital pride,⁵¹ making the person open again to emotional involvement

experiences and explications. Concerning the prospective partial situation, Schmitz (2015, 99) also refers to Jung’s anima-possession for men.

⁴⁶ Whose not pathological relationship is the basis for different constitution types (the extrovert, the introvert and the ultrovert).

⁴⁷ Essentially due to some capital errors (worldsplitting, dynamicism, autism, constellationism, singularism, ironism), which here I obviously cannot dwell upon.

⁴⁸ Cf. Werhahn (2011, 102).

⁴⁹ As is usually the case with mirsing therapy (Uzarewicz and Uzarewicz 2005, 130).

⁵⁰ See Robby Jacob in dialogue with Schmitz (Werhahn 2011, 97-100) for an example of atmospheric pride as an antidote to shame pathology, which for Schmitz is impossible on the pre-personal level and can be successfully treated thanks to an object-loss (*ipso facto* atmospheric) pride.

⁵¹ Well exemplified, for Schmitz, by the Bamberg Horseman!

thanks to the five therapeutically relevant (if reactivated) moments of the primitive presence (here, now, being, this, I) (Marx 2002, 227-228, 241-244). In general, it should not be underestimated that a neo-phenomenological base therapy must strengthen a felt-bodily threatened personality,⁵² by making it aware of being the receptacle of supra-individual events and of needing a solid vital anchoring in the present rather than in utopian superillusions.

4. After

Not much can be said about the atmospheric situation after the treatment. As has been rightly pointed out (Francesetti 2015, 8), the fact that the patient is depressed before and after the therapy session would only mean that they bring and actualise in a different way a depressive field in all the contexts they encounter. Yet, it seems to me that the therapeutic effectiveness is demonstrated only if the good setting's atmosphere does not disappear at the end of the session and accompanies the person over time, at least enabling them to live, and cope, with their disorder. But how can we be sure that this happens if, for example, an abnormal familiar dynamic and a stressful environment are exactly the pathogenic factor? How can an intercorporeal in-between, belonging neither to the therapist nor to the patient, be felt by the patient in the long term? What applies to depressive persons also applies to all patients, who "are not only affected on the primary level of the disturbance, but also suffer on the existential level on which they have to live!" (Fuchs 2013, 627).

5. To be continued

To conclude, I should at least mention some theoretical open questions.

a) As pre-reflexive synchronizations with the situations encountered, atmospheres may not be ubiquitous, but they are certainly more widespread than one consciously knows. Therefore, even situations apparently without an affective tone are something atmospheric that is felt. If nothingness cannot be reduced to propositional negation, feeling nothing could also be, in minor cases, the resonance of a dull and anonymous atmosphere, and in the most serious ones the affective but yet non-emotional schizophrenic "flat-affect".⁵³ A de-axiologisation of the very

⁵² Thus overcoming the atmosphere of unrest and inertia caused by the burnout-syndrome (Julmi and Scherm 2017, 211-213).

⁵³ It is true that "the deeper the depression, the more the affective qualities and atmospheres of the environment fade" (Fuchs 2013, 624). However, the resulting

notion of “atmosphere” that overcomes its usual bucolic-romantic *cliché*⁵⁴ is thus needed also in psychotherapy.

b) It is questionable whether atmospheres are “things” (quasi-things) that one thetically experiences or rather a space of possibility through which real things are experienced. Since the single figure is always perceived at the expense of its contextual medium, a therapist runs the risk of focusing on the patient’s transient atmosphere and not on the existential feelings that make it possible (Fuchs 2003, 75ff.). But it is slightly more complicated than this, since both the temporary-single feelings and the long-term ones, which form an emotional continuum (as already mentioned), can rightly be defined as atmospheres (obviously in a somewhat different sense): for example, both the depressive basic feeling and the excessive depressive reactivity (Schneider 2004, 119).

c) The kind of atmospheric experience is also under discussion. Does experience mean a tacit knowledge based on similarity or rather the disillusionment of expectations? In this case, an excessively draconian decision does not help either, since an atmosphere is sometimes an aggressive well “segmented” quasi-thing that attracts all our attention and sometimes, instead, it is something vaguely widespread⁵⁵ that is fostered precisely by the lack of thetic attention (through peripheral perception, in Pallasmaa’s terms) to material details which it is the irradiation of (at least in part). But there is no doubt that, while the patient’s pathological atmosphere may remain indefinite and unstable, the therapist’s atmospherical felt-bodily resonance should certainly be much more methodologically precise.

d) Could the radical neo-phenomenological externalisation of feelings perhaps be only a (weak) variant of the paranoia that explains changed feelings or even of the schizophrenic “thought insertion” with external rather than internal causes? As a provocation, one could instead say that the flat, uncanny and meaningless world of schizophrenics could be then only a strong variant of the objective-scientific *Weltanschauung*. However, there is nothing wrong in principle in seeing a pathological atmosphere “also” as a pathological form of the normal pathic and felt-bodily resonance of expressive qualities and ecstasies (of things), which I call

“feeling of not feeling”, because of pervasiveness and objectual ubiquity and arbitrariness (Fuchs 2013, 624, fn. 6), is a very atmospheric feeling itself.

⁵⁴ Even an anonymous apparatus-medicine situation remains, in fact, an atmospheric situation.

⁵⁵ Just as when a pre-Gestalt fails to reach a final Gestalt, thus giving rise (Conrad 1958) to the typical pre-delusional schizophrenic atmosphere (trema, apophany or *Aha-Erlebnis*, anastrophe, apocalipsis). Cf. also Ratcliffe (2013).

atmospheric experience (Griffero 2016b). The difference is that those who have the latter are still able to keep fluctuating between the different perspectives to which those who experience the former are, on the contrary, rigidly bound.⁵⁶ Not surprisingly, then, entering a new atmosphere, dystonic and therefore always a little uncanny (Huppertz 2005, 223), could even be considered as a (luckily) just momentary and weak delusional state.

An atmospherological approach to psychotherapy is and will always remain a philosophical one. As a certainly very questionable approach, it expects to be further reviewed on its merits and criticised like any other philosophical proposal. It consists essentially in being able to carefully assess, in their embodied-externalised nature, feelings that were believed to be private so as to atmospherically overcome their pathological effects. But any illusion should be avoided here if only because a phenomenon (even pathological), although of course not always, may change for different people and for the same person at different times (Schmitz 1990, 34). A successful therapy of psychotic disturbances, proved by a reduced use of neuroleptics and a successful management of daily routine, at least transcending the suffering through hope (Tellenbach), could only result in a kind of resilience in the face of what befalls us and nobody can entirely control (Rinofner-Kreidl 2014, 101): the ability to live “surfing” between personal emancipation and personal regression (Schmitz 2005, 107). Furthermore, would it not be wise to question today’s excessive claims of happiness?

References

- Becerra, Rodrigo. 2004. “‘Atmosphere’, a Precursor of ‘Cognitive Schemas’: Tracing Tacit Phenomenological Influences on Cognitive Behaviour Therapy.” *Indo-Pacific Journal of Phenomenology* 4: 1-13.
- Berner, Peter. 1991. “Delusional atmosphere.” *British Journal of Psychiatry* 159, 14: 88-93.
- Blankenburg, Wolfgang. 1971. *Der Verlust der natürlichen Selbstverständlichkeit—Ein Beitrag zur Psychopathologie symptomarmer Schizophrenien*. Stuttgart: Enke,

⁵⁶ Patients with mania and melancholia, for example, are trapped “within” their point of view, unable to objectively escape from its affective colouring. What is pathological in a certain experience is sometimes not the content but the inability to escape from that (Brett 2002, 335-336).

- 1995. “Das Sich-Befinden zwischen Leiblichkeit und Gefühl.” In *Leib und Gefühl. Beiträge zur Anthropologie*, ed. by Michael Großheim, 193-214. Berlin: Akademie Verlag.
- Böhme, Gernot. 2001. *Aisthetik. Vorlesungen über Ästhetik als allgemeine Wahrnehmungslehre*. München: Fink.
- Bollnow, Otto Friedrich. 1941. *Das Wesen der Stimmungen*. Frankfurt a. M.: Klosterman.
- Brett, Caroline. 2002. “Psychotic and Mystical States of Being: Connections and Distinctions.” *Philosophy, Psychiatry & Psychology* 9: 321-341.
- Burger, Walter. 2008. “Wozu braucht man in der Medizin Philosophie? Die Bedeutung der Neuen Phänomenologie von Hermann Schmitz für die Medizin.” In *Neue Phänomenologie zwischen Praxis und Theorie. Festschrift für Hermann Schmitz*, ed. by Michael Großheim, 141-149. Freiburg-München: Alber.
- Conrad, Klaus. 1958. *Die Beginnende Schizophrenie. Versuch einer Gestaltanalyse des Wahns*. Stuttgart: Thieme.
- Costa, Cristina et al. 2014. “Phenomenology of Atmospheres. The Felt Meaning of Clinical Encounters.” *Journal of Psychopathology* 20: 351-357.
- Croome, Doris. 2008. “Der Körper als Erkenntnisorgan.” In *Wie ist Psychologie möglich?*, ed. by Jan-Peters Janssen, 159-174. Freiburg-München: Alber.
- Dreitzel, Hans-Peter. 1982. “Der Körper in der Gestalttherapie.” In *Die Wiederkehr des Körpers*, ed. by Dieter Kamper and Christoph Wulf, 52-67. Frankfurt a. M.: Suhrkamp.
- Dreyfus, Hubert. 1989. “Alternative philosophical conceptualizations of psychopathology.” [http://socrates.berkeley.edu/~hdreyfus/pdf/Alternative%20\(Word98\)](http://socrates.berkeley.edu/~hdreyfus/pdf/Alternative%20(Word98))
- Emrich, Hinderk M. 2012. “Synästhesie und Suchbewegungen des Geistes im kontextuellen Raum: heilende Atmosphären.” In *Atmosphären. Dimensionen eines diffusen Phänomens*, ed. by Christiane Heibach, 193-213. München: Fink.
- Fischer, Gisela C. 2005. “Diagnostisches Denken in der Medizin.” In *Symptom und Phänomen. Phänomenologische Zugänge zum kranken Menschen*, ed. by Dirk Schmoll and Andreas Kuhlmann, 29-54. Freiburg-München: Alber.
- Francesetti, Gianni. 2015. “From individual symptoms to psychopathological fields. Towards a field perspective on clinical human suffering.” *British Gestalt Journal* 24, 1: 5-19.

- Frank, Jerome D. 1972. *Persuasion and Healing*. Baltimore: John Hopkins Press.
- Frick, Eckhard. 2005. "'Zweiführung' (Jacob Levy Moreno). Szenisches Verstehen des Symptoms in der psychodramatischen Begegnung." In *Symptom und Phänomen. Phänomenologische Zugänge zum kranken Menschen*, ed. by Dirk Schmoll and Andreas Kuhlmann, 87-112. Freiburg-München: Alber.
- Fuchs, Thomas. 2003. "Was ist Erfahrung?" In *Die Kunst der Wahrnehmung. Beiträge zu einer Philosophie der sinnlichen Erkenntnis*, ed. by Michael Hauskeller, 69-87. Kusterdingen: Die Graue Edition.
- 2008. "Ökologie des Gehirns, Von der reduktionistischen zur systemischen Neurobiologie." In *Wie ist Psychologie möglich?*, ed. by Jan-Peters Janssen, 91-105. Freiburg-München: Alber.
- 2013. "The Phenomenology of Affectivity." In *The Oxford Handbook of Philosophy and Psychiatry*, ed. by K.W.M. Fulford et al., 612-631. Oxford: Oxford UP.
- Gadenne, Volker. 2008. "Subjektivität und psychologische Wissenschaft—Zur Rolle der Erlebnisbeschreibung in der empirischen Psychologie." In *Wie ist Psychologie möglich?*, ed. by Jan-Peters Janssen, 124-138. Freiburg-München: Alber.
- Griffero, Tonino. 2014a. *Atmospheres. Aesthetics of Emotional Spaces*. London-New York: Routledge.
- 2014b. "Who's Afraid of Atmospheres (And of Their Authority)?" *Lebenswelt* 4, 1: 193-213.
- 2014c. "Atmospheres and Lived Space." *Studia Phaenomenologica* 14 (Place, Environment, Atmosphere): 29-51.
- 2014d. "Architectural Affordances: The Atmospheric Authority of Spaces." In *Architecture and Atmosphere*, ed. by Paul Tidwell, 15-47. Espoo: Tapio Wirkkala-Rut Bryk Foundation.
- 2016a. *Il pensiero dei sensi. Atmosfere ed estetica patica*. Milano: Guerini & Associati.
- 2016b. "Atmospheres and felt-bodily resonances." *Studi di estetica* 44, 1: 1-41.
- 2017. *Quasi-Things. The Paradigm of Atmospheres*. Albany (N.Y.): Suny Press.
- Großheim, Michael. 2010. "Von der Maigret-Kultur zur Sherlock Holmes-Kultur. Oder: Der phänomenologische Situationsbegriff als Grundlage einer Kulturkritik." In *Phänomenologie und Kulturkritik. Über die Grenzen der Quantifizierung*, ed. by Michael Großheim and Steffen Kluck, 52-84. Freiburg-München: Alber.

- Helferich, Christoph. 2007. "Der Raum einer Praxis: Das Setting in der Körperpsychotherapie." In *Praxis der Philosophie* (III. Jahrbuch für Lebensphilosophie), ed. by Ute Gahlings et al., 229-235. München: Albunea Verlag.
- Holzheimer, Michael. 2005. "Wie wirkt Musik als Therapie? Musiktherapie und Neue Phänomenologie." In *Symptom und Phänomen. Phänomenologische Zugänge zum kranken Menschen*, ed. by Dirk Schmoll and Andreas Kuhlmann, 271-287. Freiburg-München: Alber.
- Holzhey-Kunz, Alice. 2014. "Phänomenologie oder Hermeneutik seelischen Leidens?" In *Das leidende Subjekt. Phänomenologie als Wissenschaft der Psyche*, ed. by Thomas Fuchs et al., 33-51. Freiburg-München: Alber.
- Huppertz, Michael. 2003. "Die Kunst der Wahrnehmung in der Psychotherapie." In *Die Kunst der Wahrnehmung. Beiträge zu einer Philosophie der sinnlichen Erkenntnis*, ed. by Michael Hauskeller, 177-200. Kusterdingen: Die Graue Edition.
- 2005. "Zur Phänomenologie der beginnenden Schizophrenie." In *Symptom und Phänomen. Phänomenologische Zugänge zum kranken Menschen*, ed. by Dirk Schmoll and Andreas Kuhlmann, 204-227. Freiburg-München: Alber.
- Jacob, Robby. 2013. "Psychiatrie ohne Psyche." In *Zugang zu Menschen. Angewandte Philosophie in zehn Berufsfeldern*, ed. by Heinz Becker, 152-176. Freiburg-München: Alber.
- Janssen, Jan-Peters. 2008. "Sokrates und Faustus—Metaphern für Forschung und Anwendung der Psychologie." In *Wie ist Psychologie möglich?*, ed. by Jan-Peters Janssen, 57-75. Freiburg-München: Alber.
- Jaspers, Karl. 1962. *General psychopathology*. Manchester: Manchester University Press.
- Julmi, Christian and Scherm Ewald. 2017. "Burnout als leiblich-atmosphärische Störung." In *Körperskandale. Zum Konzept der gespürten Leiblichkeit*, ed. by Stefan Volke and Steffen Kluck, 193-219. Freiburg-München: Alber.
- Kimura, Bin. 2005. *Scritti di psicopatologia fenomenologica* (1992). Roma: Fioriti Editore.
- 2007. "Das Zwischen als Grundlage der phänomenologischen Methode in der psychiatrisch-psychotherapeutischen Praxis." In *Atmosphären im Alltag. Über ihre Erzeugung und Wirkung*, ed. by Stephan Debus and Roland Posner, 248-259. Bonn: Psychiatrie-Verlag.
- 2013. *Tra. Per una fenomenologia dell'incontro*. Trapani: Il Pozzo di Giacobbe.

- Könemann, Uwe. 2007. "Atmosphärische Gestaltungsmöglichkeiten auf einer psychiatrischen Station." In *Atmosphären im Alltag. Über ihre Erzeugung und Wirkung*, ed. by Stephan Debus and Roland Posner, 42-52. Bonn: Psychiatrie-Verlag.
- Kraus, Alfred. 1991. "Phänomenologische und symptomatologisch-kriteriologische Diagnostik." *Fundamenta Psychiatrica* 5: 102-109.
- 2005. "Phänomenologisch-anthropologische Aspekte der Diagnostik und der Klassifikation in der Psychiatrie." In *Symptom und Phänomen. Phänomenologische Zugänge zum kranken Menschen*, ed. by Dirk Schmoll and Andreas Kuhlmann, 55-71. Freiburg-München: Alber.
- Kügler, Peter. 2012. "Neurowissenschaftliche und phänomenologische Zugänge zum Bewusstsein." In *Näher dran? Zur Phänomenologie des Wahrnehmens*, ed. by Steffen Kluck and Stefan Volke, 220-242. Freiburg-München: Alber.
- Langewitz, Wolf. 2008. "Der Ertrag der Neuen Phänomenologie für die Psychosomatische Medizin." In *Neue Phänomenologie zwischen Praxis und Theorie. Festschrift für Hermann Schmitz*, ed. by Michael Großheim, 126-140. Freiburg-München: Alber.
- 2013. "Die Neue Phänomenologie in der Psychosomatik." In *Zugang zu Menschen. Angewandte Philosophie in zehn Berufsfeldern*, ed. by Heinz Becker, 177-200. Freiburg-München: Alber.
- Leder, Drew. 1990. *The Absent Body*. Chicago-London: UC Press.
- Lorenz, Claudia and Penzel Joachim. 2007. "Ein atmosphärischen Rundgang durch ein Kinderkrankenhaus." In *Atmosphären im Alltag. Über ihre Erzeugung und Wirkung*, ed. by Stephan Debus and Roland Posner, 53-65. Bonn: Psychiatrie-Verlag.
- Marcinski, Isabella. 2017. "Hunger, Schmerz, Ekel, Frieren: Leib und Körper in der Anorexie." In *Körperskandale. Zum Konzept der gespürten Leiblichkeit*, ed. by Stefan Volke and Steffen Kluck, 169-192. Freiburg-München: Alber.
- Marquard, Odo. 1989. *Farewell to Matters of Principle: Philosophical Studies* (1981). New York-Oxford: Oxford UP.
- Marx, Gabriele. 2002. "Phänomenologie der Veränderung-Sprechenlernen über die erfahrbare Wirklichkeit. Anregungen der Neuen Phänomenologie für die Psychotherapie." In *Begriffene Erfahrung. Beiträge zur antireduktionistischen Phänomenologie*, ed. by Hermann Schmitz et al., 222-249. Rostock: Koch Verlag.
- 2005. "Leiblichkeit und Personalität in der psychotherapeutischen Situation." In *Symptom und Phänomen. Phänomenologische Zugänge zum kranken Menschen*, ed. by Dirk Schmoll and Andreas Kuhlmann, 230-242. Freiburg-München: Alber.

- 2008. “Zentrale Begriffe der Neuen Phänomenologie und ihre Bedeutung für die Psychotherapie.” In *Neue Phänomenologie zwischen Praxis und Theorie. Festschrift für Hermann Schmitz*, ed. by Michael Großheim, 170-180. Freiburg-München: Alber.
- 2013. “Das Nachhaltige und das Flüchtige—was bleibt von Psychotherapie?” In *Zugang zu Menschen. Angewandte Philosophie in zehn Berufsfeldern*, ed. by Heinz Becker, 134-151. Freiburg-München: Alber.
- Moldzio, Andrea. 2002. “Verletzte Leiblichkeit.” In *Begriffene Erfahrung. Beiträge zur antireduktionistischen Phänomenologie*, ed. by Hermann Schmitz et al., 250-266. Rostock: Koch Verlag.
- 2005. “Zur schizophrenen Entfremdung auf der Grundlage der Neuen Phänomenologie.” In *Symptom und Phänomen. Phänomenologische Zugänge zum kranken Menschen*, ed. by Dirk Schmoll and Andreas Kuhlmann, 185-203. Freiburg-München: Alber.
- 2008. “Zur philosophischen Fundierung psychotherapeutischen Handelns und Denkens.” In *Neue Phänomenologie zwischen Praxis und Theorie. Festschrift für Hermann Schmitz*, ed. by Michael Großheim, 158-169. Freiburg-München: Alber.
- Nagel, Thomas. 1986. *The View from Nowhere*. New York: Oxford UP.
- Paduanello, Matteo. 2015-2016. “Il sentire atmosferico in fenomenologia e psicopatologia.” *Comprendre* 25-26: 279-301.
- Ratcliffe, Matthew. 2008. *Feelings of Being. Phenomenology, Psychiatry and the Sense of Reality*. Oxford: Oxford UP.
- 2010. “Delusional Atmosphere and Delusional Belief.” In *Handbook of Phenomenology and Cognitive Science*, ed. by Shaun Gallagher and Daniel Schmicking, 575-590. Dordrecht: Springer.
- 2013. “Delusional Atmosphere and the sense of unreality.” In *One Century of Karl Jaspers’ General Psychopathology*, ed. by Giovanni Stanghellini and Thomas Fuchs, 229-244. Oxford: Oxford UP.
- Reuster, Thomas. 2005. “Integrationsprobleme in Psychiatrie und Medizin.” In *Symptom und Phänomen. Phänomenologische Zugänge zum kranken Menschen*, ed. by Dirk Schmoll and Andreas Kuhlmann, 72-86. Freiburg-München: Alber.
- Rinofner-Kreidl, Sonja. 2014. “Intuition und Resilienz.” In *Das leidende Subjekt. Phänomenologie als Wissenschaft der Psyche*, ed. by Thomas Fuchs et al., 75-103. Freiburg-München: Alber.
- Sass, Louis. 1992. *Madness and Modernism: Insanity in the Light of Modern Art, Literature, and Thought*. New York: Basic Books.
- Sass, Louis A. and Pienkos Elisabeth. 2013. “Space, Time, and Atmosphere. A Comparative Phenomenology of Melancholia, Mania,

- and Schizophrenia, Part II." *Journal of Consciousness Studies* 20, 7-8: 131-152.
- Schmidt-Degenhard, Michael. 1995. "Interpretative Situageneseforschung." *Fundamenta Psychiatrica* 9: 46-51.
- Schmitz, Hermann. 1965. *System der Philosophie*. Bd. II.1, *Der Leib*. Bonn: Bouvier.
- 1980a. *System der Philosophie*, Bd. IV: *Die Person*. Bonn: Bouvier.
- 1980b. *System der Philosophie*, Bd. V: *Die Aufhebung der Gegenwart*. Bonn: Bouvier.
- 1989. *Leib und Gefühl. Materialien zu einer philosophischen Therapeutik*. Paderborn: Junfermann-Verlag.
- 1990. *Der unerschöpfliche Gegenstand. Grundzüge der Philosophie*. Bonn: Bouvier.
- 1998. "Situationen und Atmosphären. Zur Ästhetik und Ontologie bei Gernot Böhme." In *Naturerkenntnis und Natursein. Für Gernot Böhme*, ed. by Michael Hauskeller et al., 176-190. Frankfurt a. M.: Suhrkamp.
- 2002. *Begriffene Erfahrung. Beiträge zur antireduktionistischen Phänomenologie*, with Gabriele Marx and Andrea Moldzio. Rostock: Koch Verlag.
- 2005. *Im Dialog. Neun neugierige und kritische Fragen an die Neue Phänomenologie*. With Wolfgang Sohst. Berlin: Xenomoi.
- 2008. "Psychologie als Wandschaft zwischen zweimal zwei Welten." In *Wie ist Psychologie möglich?*, ed. by Jan-Peters Janssen, 21-34. Freiburg-München: Alber.
- 2010. *Jenseits des Naturalismus*. Freiburg-München: Alber.
- 2015. *Selbst sein. Über Identität, Subjektivität und Personalität*. Freiburg-München: Alber.
- Schmoll, Dirk. 1995. "Leib und Psychose." In *Leib und Gefühl. Beiträge zur Anthropologie*, ed. by Michael Großheim, 229-240. Berlin: Akademie Verlag.
- Schneider, Kurt. 2004. *Psicopatologia clinica* (1980). Roma: Fioriti Editore.
- Schottenloher, Gertraud. 2010. "Gedanken zur Atmosphäre in der Kunsttherapie." In *Gretchenfragen: Kunstpädagogik, Ästhetisches Interesse, Atmosphären*, ed. by Stefan Graupner et al., 209-217. München: kopaed.
- Sloterdijk, Peter. 2011. *Spheres. Vol. 1: Bubbles. Microspherology*. Los Angeles: Semiotext(e).
- Sonntag, Jan. 2013. *Demenz und Atmosphäre. Musiktherapie als ästhetische Arbeit*. Frankfurt: Mabuse-Verlag.

- Stanghellini, Giovanni. 2017. *Lost in Dialogue. Anthropology, Psychopathology, and Care*. New York: Oxford UP.
- Stoffels, Hans. 2005. "Situationskreis und Situationstherapie. Überlegungen zum einen integrativen Konzept von Psychotherapie." In *Symptom und Phänomen. Phänomenologische Zugänge zum kranken Menschen*, ed. by Dirk Schmoll and Andreas Kuhlmann, 166-184. Freiburg-München: Alber.
- Stoerring, Gustav. 1987. "Perplexity." In *The Clinical Roots of the Schizophrenia Concept*, ed. by John Cutting and Michael Shepherd, 79-82. Cambridge: Cambridge University Press.
- Tellenbach, Hubert. 1968. *Geschmack und Atmosphäre. Medien menschlichen Elementarkontaktes*. Salzburg: Otto Müller Verlag.
- Töpfer, Frank. 2007. "Das Leib-Seele Problem in der phänomenologischen Psychiatrie und die Grenze existenzialer Anthropologie." In *Das Leib-Seele Problem und die Phänomenologie*, ed. by Cathrin Nielsen et al., 211-235. Würzburg: Königshausen & Neumann.
- Ulrich, Roger S. 1984. "View through a window may influence recovery from GP practice." *Science* 224: 420-421.
- Uzarewicz, Charlotte and Uzarewicz Michael. 2005. *Das Weite suchen. Einführung in eine phänomenologische Anthropologie für Pflege*. Stuttgart: Lucius und Lucius.
- Van den Berg, Jan Hendrik. 1955. *The Phenomenological Approach to Psychiatry. An Introduction to Recent Phenomenological Psychopathology*. Springfield (Ill.): Thomas.
- Werhahn, Hans, ed. 2011. *Neue Phänomenologie. Hermann Schmitz im Gespräch*. Freiburg-München: Alber.

CHAPTER TWO

A CLINICAL EXPLORATION OF ATMOSPHERES: TOWARDS A FIELD-BASED CLINICAL PRACTICE

GIANNI FRANCESSETTI

1. Introduction

*Just a few metres away and I'm alone,
in terrible space, in terrible time.
Then a body,
removed from the symbolic sounds of a hello, how are you,
is flung into the distance.
We have to call out to each other, continuously*
Mariangela Gualtieri (2003)

The concept of atmosphere has been widely explored by philosophy, especially in aesthetics (Griffero 2014; Böhme 2010, 2017; Schmitz 2011). In psychopathology, however, it has instead been used sporadically and by only a few, albeit authoritative, authors, from Karl Jaspers (1963) through to Hubertus Tellenbach, in particular (2013; see also Costa et al. 2014). Although such contributions have been few and far between, and are largely neglected by debate in psychiatry and psychotherapy today, they are particularly interesting because they point to and support a conception of psychopathology that goes beyond a symptomatic and individualistic understanding of human suffering. The dominant paradigm in clinical psychotherapy and psychiatry today makes use of third-person descriptive diagnosis and clinical work aims at changing the way the patient (dys)functions. Such an approach is far from satisfactory. To begin with, a diagnosis that is limited to comparing observable traits to a set list of symptoms is highly problematic (Migone 2013; Barron 1998; Borgna 1988; Francesetti and Gecele 2009) and inevitably tends to neglect the specificity and richness of the patient's experience. That constitutes a

major loss for therapy, but also for the potential clinical practitioners who have to learn from the singularity of each of their patients and open up their conception of psychopathology towards new horizons. Moreover, by limiting the scope of action to modifying dysfunctions in the patient, the risk is that the functional purpose of the symptoms fails to be grasped and the transformative meaning of suffering overlooked, while suffering itself is attributed entirely to the patient, without taking into account co-creation phenomena in psychotherapy in the therapy setting. Such an approach has not proven to be successful in addressing the problems it promised to resolve (Bracken et al. 2012).

In this chapter, I will attempt to describe how the concept of “atmosphere” can help open up a different understanding of psychopathology, diagnosis, and clinical practice. I will also attempt to show how the concept can help steer us towards an *aesthetic diagnosis* that goes beyond the diagnosis of symptoms, and towards a *field-based clinical practice*, which goes beyond the individual. It is a paradigm shift that will lead us onto new epistemological ground, one that is different from the individualistic perspective where clinical work focuses on the suffering individual to effect change, but also from the bi-personal paradigm which sees the relationship co-created by two individuals who come together and jointly produce change. This new horizon *posits the relationship before the related*, where subjects and the world emerge incessantly from an undifferentiated ground in which they are not yet defined. As such, even suffering and therapy come from something much vaster than the people involved—the patient and the therapist—who therefore find themselves in a landscape that imposes limits, but also offers possibilities.¹ To affect this shift in perspective, we need to focus on the original and constituent *momentum* from which we move and which continuously moves us. A *momentum* which, although it is constituent, is ephemerally changing, and hence open and tending in and of itself to evolve. Change happens only if there is a sufficient degree of freedom and support for the movement that is already in the making in the situation. Thus, we find ourselves squarely in a field perspective, where emergent phenomena are seen as the ecstatic manifestations of the situation and its tendencies towards new forms.

Thus, the aim of this chapter is to chart a journey towards a field paradigm in psychopathology and psychotherapy—a journey in which we will inevitably encounter *pathos* and *atmos*.

It should be stressed that my intention here is not to propose the perspective as an alternative to a mono-personal or bi-personal approach. Rather, I wish to present a Field-based Clinical Practice from which

¹ See the chapter by Jan Roubal in this volume.

therapists and supervisors can draw to broaden the possibilities of therapy, by shifting—with awareness—between an individualistic, co-creative and field-based approach. Of course, I consider this last perspective to be the most radically relational, which is why in moments of impasse, when the therapist finds himself profoundly involved, the field perspective becomes particularly useful, at times even necessary, to make sense of the situation and find new openings for the therapy process.

2. “We are the form / that forms blindly / in talking about itself / by vocation”

The pathic dimension, where the subject and the world co-emerge

*If our place is where
silent contemplation among things
needs us
saying is not knowing, it is the other
all fated path of being.
This is the geography.
That is how we stay in the world
pensive adventurers of humanity,
that is how we are the form
that forms blindly
in talking about itself
by vocation*
Silvia Bre (in Buffoni 2016, 33)

In the group, Anna asked me to work with her.² Since that morning, I had seen her visibly touched and moved by something that had emerged from the theoretical folds of the discussion on anxiety and panic that we had placed in the field. After the lunch break, the group preferred to stay in the background for a while. It wasn't the time for theory or small group work. Anna stepped forward, proposing personal work. It seemed like a good time for it, the group was supportive. As I have been doing for several

² At the start of this section and the following sections, I have provided a partial transcript of a session conducted at a theoretical and experiential seminar. My aim is to describe, as best I can, some crucial passages of a therapy session and the experiences of the therapist, in the hope of illustrating the theoretical aspects addressed in this chapter, in particular the concepts of patic, atmosphere, intrinsic diagnosis (resonance and *atopon*) and how the therapist modulates his presence in lending his flesh to support the transformative processes at play.

years now, I asked Anna to choose where she wanted to sit in relation to me, and invited the members of the group to sit wherever they wished in the room, at whatever distance they felt they wanted to stay. This helps me feel the presence of the group more and it seems as though people tend to arrange themselves along invisible force lines of the field, like iron filings on a piece of cardboard held over a magnet. We start. Anna sits in front of me. The group arranges itself around the room. I adjust myself on my seat and take a deep breath. I try to find the right position, a mid-way point between myself and the environment (I don't know how else to put it), so that nothing is already a figure. I get ready for anything I might feel sitting here opposite her. I brace myself for that tough moment in which I feel nothing and have to remind myself to be patient, but also for the moment when I feel something I would rather not feel, and have to remind myself that nothing wrong is happening and to be careful not to discard it. My body is here, waiting, giving neither form nor direction to anything. Anna and I look at each other. Her blue eyes cannot resist mine and glance elsewhere, as she smiles and leans forward slightly, resting her hands on the frame of her seat. Her jaw looks like it's trembling slightly. Something is moving, but I don't know what. I swing between feeling nothing—with some horror, a little too much it seems to me—and feeling that something is affecting me, but I don't know what.

In ordinary, everyday life, we live in a world in which subject and object are givens, separate figures that are not problematic. Husserl calls this mode of experience the *natural attitude* (Husserl 1931), where objects are something given, something out there that I can perceive as separate from me. That attitude is the starting point for how the subject enters into contact with the world—cognitively, emotionally, affectively, and behaviourally. It is a perspective that underpins the conception of the mono-personal mind, giving rise to a psychopathology that treats suffering as a dysfunction in the patient and therapy as a means of correcting that malfunction. One way of overcoming that approach is to observe how subjects interact with each other and with the environment, and how artificial it is to abstract them from each other and the world they live in: the isolated individual does not exist. Such a position has radically characterised Gestalt Therapy ever since its beginnings (Perls, Hefferline and Goodman 1994), alongside the systemic perspective (Bateson 1979) and, more recently, psychoanalysis (albeit not in all its currents), through Sullivan's interpersonal psychoanalysis and, later, the so-called "relational turn" (Greenberg and Mitchell 1983; The Boston Change Process Study Group 2010; Lingardi et al. 2011). In this way, we have moved towards a

paradigm—what we might call the paradigm of the bi-personal mind—where subjects co-create their experience and together affect change. There exists a more radical paradigm, however, where subjects are not given, but emerge themselves from something that comes before them. Indeed, as Husserl teaches, the natural attitude is not an unequivocal description of reality, of *how things really are*, rather, it is the outcome of a process that constitutes experience in that way. We see the vestiges of this process in the words *subject* and *object*: *sub-jectum*, in the Latin, means cast down below, *ob-jectum* means cast out there, thus bearing evidence of their not being original essences but the product of the act of being cast into two different regions of the experience. German Berrios (Marková and Berrios 2012) notes how the current meaning of “object”, as something independent, and subjective, as something mental and relative to the individual, only developed during the XVII century with the establishment of the scientific method. Before then, the terms were used to mean the outcomes of a process. Even in physics, objects are no longer, and have not been for quite some time, the stable objects of Newtonian physics (as we perceive them to be with the natural attitude), but energy processes which collapse perceptively into “things” that exist in a space-time that is itself created by neurological processes (see, for example, Schrödinger 1944; O’Neill 2008; Rovelli 2016). Hence, if the world as we conceive it—a world inhabited by subjects separated from stable objects—is the outcome of a process, what can we say about the process itself?

Let’s start with the work of Gestalt psychology on perception and follow the analysis of Klaus Conrad,³ in particular the work of Metzger (1971). These researchers provided empirical evidence showing that perception is a process which, in just fractions of a second, leads to a perceptive experience in which the subject perceives himself as separate from the object, where the subject is detached both spatially and emotionally and the object possesses a clear, definite outline. This outcome of perception, which Metzger called *Endgestalt* (final Gestalt) is the result of a process that arises from a very different, original perceptive moment. The perceptive forms of that initial moment are called *Vorgestalten* (pre-Gestalten). With *Vorgestalten* the perceptive experience is diffuse, undifferentiated, and global. The figure has yet to stand out separately from the background; something is there, but it is an unstable, confused and indefinite presence. It is an experience of non-rest, and hence of restlessness, before a subject is distinguished clearly from an object. In this first phase, *expressive physiognomic qualities* predominate—

³ Conrad was the first to define and use a method of investigation in psychopathology which he called “Gestalt analysis” (Conrad 1958).

qualities that are affectively charged, which communicate something in an immediate, pre-reflexive way. They are experienced in a passive way, as though seizing the subject, giving rise to a sense of expectation of development, of a purpose that has yet to be defined here, and if that development is delayed, tension emerges and restlessness grows. When Endgestalten finally emerge, *structural-material qualities* are what predominate, characterised by a feeling of relief in perceiving a distinct figure which objectively stands out and from which the subject feels he is separate and in a position to observe with critical judgement and emotional detachment. The sensation of being passively drawn into something indistinct and disturbing ends.

This Gestalt analysis of perception is in line with the description of the emerging of the self developed by Antonio Darnasio (2012).⁴ According to this model, based on his neurological studies, during the process of perception the self “comes to mind”, emerges progressively, in stages: the proto-self, the subjective self, and the autobiographical self. In the original, initial stage, the proto-self is alerted to the presence of *something*, without it being clear *what* it is or *who* it belongs to. A state of rest becomes a restlessness that cannot be attributed to me as a subject yet, it is not yet *my* sensation, because the sense of being a separate subject will only emerge at a later moment. From another perspective, the concept of the *emergent self*, developed by Daniel Stern (1985), also embraces this initial datum of all experience. The emergent self characterizes the first couple of months of life of infants. At this time of childhood development, there is no definite sense of self yet, nor is it clearly and stably distinct from the world; rather it is the *emergent process* of the self that is figure. In Stern’s model, the stages we go through in development are present in every subsequent experience, in every moment for the rest of our lives. These three empirical explorations (Gestalt psychology, neurosciences, and infant research) support the phenomenological perspective, a philosophical tradition that points to an original dimension of experience in which subject and object are yet to be differentiated and describes the natural, naive attitude (Husserl 1931) that normally characterizes perception as a product and not as an original experiential datum, although we normally pay no attention to it (Merleau-Ponty 2003; Alvim Botelho 2016; Waldenfels 2011).

With *Vorgestalten* at the origin of all perception, the experience is atmospheric and pre-dualistic, lying at the basis of our pathic life (Tellenbach 2013; Griffero 2014; Böhme 2010, 2017; Schmitz 2011; Francesetti 2015a). *Pathic* (or *pathos* - πάθος) refers to what we feel

⁴ Cf. <https://www.youtube.com/watch?v=8LD1307dkHc>

immediately and passively. We are seized by the pathic; we do not choose it, we are moved by it; pathic has the same root as passion and pathology, both happen to us and take us without choice: it is something *to which* we are subject (rather than *of which* we are subject). The construct of *being moved*, and its implications for psychopathology, is not very well developed in psychology yet, but a growing interest can be found in the recent literature (Menninghaus et al. 2015). Pathos eludes causal logic since that “by which” we are moved cannot be grounded in something earlier than us, in the sense that what comes before the emergence of “me” is not some-thing that is already defined. Pathos emerges by its nature from mystery, from the mysterious and impenetrable dimension from which experience originates: “we start elsewhere, in a place where we have never been and will never be” (Waldenfels 2011, 84). The pathic dimension is by definition alien to the subject, as it is situated at the root of the emerging of the subject, when the subject has yet to be formed, moving it by calling it to respond, incessantly. Its contrary is apathy: “once the ‘affective relief’ (*Hua* XI, 168; *ACPAS*, 216)⁵ is flattening, an experience goes to sleep” (Waldenfels 2011, 27). It is the phenomenon of coming to light, of origination pressing its way to find form and life. The logic here is one of emergence, leading us to the epistemology of complexity (Morin 2008; Maturana and Varela 1992), chaos (Gleick 1987), and non-equilibrium (Prigogine 1997), and not the linear logic of cause and effect. The patient, by definition, is who suffers what he feels, which implies that he is not free to feel anything else. In this way, therapy, as we will see further on, can be considered a process that broadens the freedom in responding to pathos in the therapy session.

This paradigm in which subjects emerge from the undifferentiated ground of the situation can be found in the conception of the self, developed in PHG (1951) at the very origins of Gestalt Therapy, where the self is not an individual attribute, but emerges as an expression of the situation itself, and the possibility of exercising choice is itself a product of the making of the self in each and every situation (Robine 2006; Philippon 2009; Vázquez Bandín 2014).⁶

⁵ Husserl, Edmund. 1966. *Analyzen zur passiven Synthesis* (= *Hua* IX). The Hague: M. Nijhoff (English translation: *Analyses Concerning Active and Passive Synthesis*, trans. by Anthony J. Steinbock. Dordrecht: Kluwer, 2001 (= *ACPAS*).

⁶ For more on this, see Robine (2016).

3. “There you are at the origins / and to decide is foolish: you depart later / in order to assume a face.”

The atmos and its traces

*There no one scrutinizes himself
or stands apart hearkening.*

*There you are at the origins
and to decide is foolish:*

you depart later

in order to assume a face.

Eugenio Montale, *Portovenere* (in Cary 1993, 257)

Something weighs on the air. The wait—just a few seconds, probably, before Anna starts speaking—becomes loaded with unexpected pressure, as though all of a sudden we had fallen into a dense liquid. Cubic metres of ocean bear down on us; I can especially feel it weighing down on my chest. My sight is hazy. I don’t try to move, but I know that if I did my movements would be slowed down by the viscosity of the medium. It is shapeless, and I don’t want to stay here a moment longer. Fortunately, Anna starts talking. It’s a relief, and the liquid dissolves, turning back into the air. “I’ve had a stomach ache since this morning, and I’m afraid somebody might die—my husband, myself, or my son.” Now she is trembling. The weight on my chest has transformed into a weight in the pit of my stomach. I feel a strong urge to go away. I don’t want to be here anymore, I want to escape. I find it highly inappropriate, cowardly even. I don’t understand this urge to go away and leave her on her own.

In the sensorial dimension of the pathic, in the moment of the *Vorgestalten*, perception is atmospheric; it is what Minkowski (1927) calls the “vague and confused”. It is something I perceive somewhere in the air, without being able to attribute it to myself or to the other—or rather, calling it “something” is too defined, but it certainly is not nothing. In that hiatus without language, the word *almost-entity* or *quasi-thing* comes to the rescue, indicating an atmospheric that has yet to precipitate into a subject or into an object (Schmitz 2011). As Schmitz conceives them, atmospheres exist in the environment independently of the subject, seizing it from the outside. That is not the case, however, in the perspective I am presenting here. Rather, the atmospheric is the way we originally, vaguely, and globally perceive the situation, before subject and object stabilize into stable poles, and hence without being able to situate what we feel completely inside or outside of us. In the atmospheric, figure and background are not yet defined, but form an affectively charged tone that

is diffuse in space, immediate and without clear boundaries, from which subject and object will emerge, impregnating and colouring the nascent experience, which encompasses subjects and objects in a reciprocal, circular making. We could say that it is here that the experience consists of observing objects which in turn observe us, in that they have yet to be constituted stably as objects and imbued with subjectivity. Space itself and time are far from the objective characteristics we attribute to clock time and metric Euclidean space. If we consider the natural attitude as being the ordinary state of consciousness, then the nascent state of perception is clearly an altered state of consciousness. This is the dimension of the *Unheimlich*, “the uncanny”⁷ described by Freud (1970), which we encounter when something is perceived as both familiar and strange at the same time, hovering between the animate and the inanimate, the living and the dead, the new and the well-known, revelation and homeliness.⁸ In that initial moment there is no clear distinction between different senses and the perception tends to be synaesthetic (Merleau-Ponty 2003; Masciandaro 2016; Griffero 2014, 2016). The pathic is felt as something that just *happens*, well before it *happens to me*, as it is from that happening, which needs to be attributed, that a “me” is constituted. It begins as shapeless and then takes shape, inevitably losing in the process certain characteristics of shapelessness. It happens in the region of what is not yet effable, and hence it is ineffable. Since it is an ante-predicative and pre-reflexive moment, the translation of this experiential moment into language cannot be taken for granted. Language, in fact, is an expression of a universal grammar (Chomsky 1968), which has a subject + verb + object structure. In such a grammar, the atmospheric experience of pathos, where subject and object have yet to be differentiated, cannot be expressed. Thus, there is a constituent incommensurability between that moment of experience and language, and the word can only approximate the welling moment of experience, which remains ineffable. But that approximation, that circling around lived experience without ever managing to capture it—a phenomenon that I call aesthetic excess (Francesetti 2017)—is the fount of the constant search, birth and rebirth of the word, just as is the case for incommensurable numbers, such as *pi*, which can only be approximated because they are never ending and the closer one comes to pinning them down, the more decimal points emerge, forever to infinity (Mazzeo 2013). When language does manage to latch onto this moment, it becomes poetry (PHG, Ch. 7)—but here we are not talking about formal poetry, but rather the living language defended by Paul Goodman, distinct from both

⁷ I thank Carla Martinetto for her contribution to this passage.

⁸ See the chapter by Fuchs in this volume.

objective scientific prose and the distant, neurotic verbalization of lived experience. By reifying and crystallizing subject and object as polar opposites, modern Western culture, ever since Descartes at least, has neglected the phenomena that occur between them in the instability of their emergent moment. This is captured in what PHG calls the “disease of language” (1994, 155 footnote), a disease which permeates modern Western culture, which has lost the *middle mode*, a grammatical structure present in ancient Greek which describes an experience that falls neither entirely with the subject or the object, but which lies in a middle realm where the subject and object play and are played with, and which would be able to express the co-originality and reciprocity of me and the world (Sichera 2001; Francesetti 2012, 2015a). This language disease expresses a cultural disease, of having lost sight of the phenomena that populate the middle realm and which are not ascribable or reducible to an event that is either subjective or objective. A verbal form is lacking to describe its spontaneity, for it is “both active and passive [...] it is middle in mode, a creative impartiality” (PHG 1994, 154). Thus, the linguistic expression of the atmospheric would appear to face a constituent hurdle tied to the problem of expressing what is undifferentiated in language (which by its nature differentiates subject and object), as well as a cultural hurdle tied to the specificities of a mindset that jumps between the hyper-defined opposites of objectivity and subjectivity, without ever stopping to notice the nascent phenomena between them.

The atmospheric is, therefore, and first of all, vaguely corporeal and only later verbalizable. But since it is pathic, its corporeality is not something that is given as “mine”. Rather, it is the alien that emerges and defines a “me” by its difference—it is the out of place, the uncanny, the *atopon*, from which the novelty of the world emerges (Francesetti 2019, in press). *Atopon*, from the Greek, means out of place: “Gadamer reminds us that the Greeks had a word for that which brings understanding to a standstill. That word was *atopon*, which in reality means ‘that which cannot be fitted into the categories of expectation in our understanding and which therefore causes us to be suspicious of it’” (Costa et al. 2014, 356).

In psychopathology, psychotic experience itself can be viewed as a disruption in the coming into being of subjectivity, in the emergence of subject and world as distinct, but at the same time appertenant to each other. In schizophrenic experience, the boundary is not clearly given and subject/object are not stable categories, for which one’s experience is not stably one’s own and the other’s experience is not stably the other’s. The patient may feel, for instance, that the other’s gaze is penetrating his mind and stealing his thoughts, or that the mysteries of the universe are revealed

to him directly. In melancholic experience (the other typical kind of psychotic experience), the patient's experience of space and time is not felt to be shared and she feels disconnected from a common world which she struggles to be a part of. Thus, psychotic experience can be seen as the outcome of a disruption in the process of constituting experience according to transcendentalisms that enable us to take it for granted that our experience is a part of a common and shared world, to which we are connected, but separate. Disturbances of the *minimal self*, or of the feeling that an experience immediately belongs to oneself, as evidenced by various authors (Zahavi 2017; Ratcliff 2017), are a disturbance in these transcendentalisms, as feeling something to be one's own presupposes a "me" that is not yet distinctly constituted here. People who have psychotic experiences live in the atmospheric, in the glowing hot crucible from which subject and world struggle to emerge without managing to. The drama here lies not only in the anguish for a separate world which fails to be constituted, but also in the lack of a language to convey the experience in communicable terms. The artistic and poetic capacity of those who have psychotic experiences also lies in the extreme struggle between the unspeakable and the urge to speak: madness is thus seen clearly here as the unfortunate companion of poetry (Clemens Brentano, quoted in Béguin 1939). Even delusion is a creative attempt to give narrative form to unspeakable anguish, and hallucination an extreme attempt to constitute an object out in the world, distinct from oneself. The same problem of language arises every time we find ourselves in situations where the pathic is amplified and we take a step back from the natural attitude, such as in altered states of consciousness and mystic states, regardless of how they are elicited. Here, the perceptive process is altered and we are unable to reach an ordinary, natural attitude; pathos, namely the sense of being absorbed by the alien, becomes overwhelming and communication constitutively problematic.

Hence if we focus on the nascent state of perception, we encounter the pathic and atmospheric, from which subjectivity and the world will finally take shape. A shape that is never stable, as it is continuously shifted by the invasion of the alien pathic. A sensorial and corporeal dimension in dynamic tension with the reflexive and linguistic dimension, which feeds from the former and circularly feeds back into it, bearing its traces. The capacity to let oneself be absorbed by the atmospheric and feel the pathic, to be moved and to let the alien emerge, is the same capacity for being alive; it is contact with the world-of-life. Without novelty—which cannot

but be alien-invading feeling, the flesh⁹ is dulled and dies. If the self emerges from the pathic, without the pathic there cannot be a self. Only the *other* can give me my flesh, which s/he does not have: “My flesh vanishes when its unique condition of possibility, the flesh of the other, disappears” (Marion 2007, 119). Only by feeling that which is not already mine—that which is other, *unheimlich* and alien—can I find myself and feel myself alive.

A number of ethical implications can be developed from these premises (Bloom 2013), which, however, transcend the purposes of this chapter. Nevertheless, what I would like to point out here is how to take in the alien pathic, lending it flesh as the only way to receive one’s own, points to a rather precise way of being with the other, where only by taking in the alien can we feel ourselves—and hence be-alive—and renew ourselves—and hence be-new. The opposite of pathic is apathy and indifference, an all-important ethical issue for our times, on which this perspective can help offer new windows for thought.

4. “So much sparkle in us that urges to combust in flames.”

**Psychopathology in a field perspective:
suffering that is revived in the atmosphere
of the encounter**

*A century of dust weighs
On our eyelids and
Rubble in the chambers
Of the heart
[...]*

*So much sparkle in us that urges
to combust in flames. To dry up
Into a diamond.*

Mariangela Gualtieri (2010, 129)

Anna says she’s had a happy life, that she loves and is loved, and finds joy in her work. But she is profoundly troubled by this overriding fear of something happening, that someone could die and everything could be lost. It overwhelms her at times, becoming overriding anxiety and

⁹ I use the term “flesh” (*chair* in French) in the meaning given it by Jean-Luc Marion (2007), along the lines of French phenomenological literature, starting from Merleau-Ponty (2003). The terms corresponds, more or less, to “Leib”, as used by German authors, starting from Husserl (1931).

insomnia. Yet there's no reason for it, she says. During the seminar, the fear becomes more intense, to the point of wanting to run away and go home, back to her husband and son. As we talk, the conversation becomes more and more fluid, and I no longer want to run away; nor does she. It's easy to talk to her, pleasant, carefree. I feel at home in this, but the trace, the fear, the weight from before has not entirely left me. I'm stunned at how easily we have come to talk with such ease. Where did that heavy ocean go, that weight that oppressed me so intensely and so suddenly just shortly before? I ask her where her fear is now. Anna says, "It's not here anymore." "And what does your body feel?" Anna replies, "I'm fine... though... it's like I have a stone in my tummy, here at the pit of my stomach... I realize now that I've got used to it." So that's where all those cubic metres weighing down on the room have gone, I think. A dark mass of ocean that has solidified into a small stone, into an Amen. "Put your hand there, on the stone..." Anna presses her knuckles against her stomach, the same way I remember my medical semeiotics professor used to do when I was an intern in hospital—an explorative and invasive gesture, exactly how you would look for a stone in the gut. "No, wait, do it more softly, like this..." I show her how using my own hand on my stomach. Anna nods and adjusts her hand. Her touch is softer now, more gentle. She starts to cry. Something mobile and warm moves between us. It reaches me, touches me, and saddens me. It does me good.

Identifying and valuing the atmospheric pathic dimension, as we have sought to do, enables us to focus on the fact that in the therapy session, the patient and therapist emerge from a pre-dualistic and undifferentiated dimension. The experiential phenomena of their coming together emerge within a horizon of possible forms that I call the *phenomenal field* (Francesetti 2019, in press). They are perceptible as an atmosphere, an affectively-charged space-time made up of horizons of restraints and potentialities. In the phenomenal field of the specific session, certain phenomena can emerge while others cannot, well before any choice can be exercised. It is pathos that absorbs us and gives us shape within the present therapeutic situation. Neither the therapist nor the patient choose what to feel—that happens on its own, within the limits of possibility of the encounter itself. As it is a therapeutic encounter, the forms that emerge follow the intentionalities of caring and seeking care, for which suffering and transformation acquire particular importance. To suffer, from the Latin *sufferre* (from *sub*, “from below” and *ferre* “to bear”) means to bear upon oneself. The patient is therefore he who bears something and brings it to the therapist. What does he bring? First of all, he brings what he

himself suffers, something which he can neither choose to bear or not bear, which is pathos. What the intentionality of the therapeutic situation entails is that the patient brings to the therapist the pain of his personal story, which he has not been able to face, which is revived here so as to be faced. If that pain has not been faced it is because the conditions did not exist for that to happen, *first and foremost* the presence of the other. The assumption here is that the pain needs the flesh of the other to be faced. To give an example, a child who is the victim of neglect, mistreatment or abuse is a child that has experienced the absence of the other and bears within her an embodied memory. Absence is not just when the other was away (as may be the case with neglect). Rather, and above all, it is when a person was physically present but absent in the relationship, showing no respect for dignity, uniqueness, otherness, needs and the call for love. That child will be unable to assimilate her pain upon herself because that would be the outcome of a “good formulation” of what happened, which is only possible if it is processed relationally, and so assimilated. Instead she will give that memory the least intrusive form possible, through dissociation, for instance, which will enable the emotional pressure of the experience to be reduced—in part, at least. Thus, suffering will be borne as absence, as an impossibility of being fully present in the relationships of her life, where the dissociated affects are relevant. What is brought to the therapy session, therefore, is not the form of her pain but the way the memory has been borne up until the here and now. What arrives is an absence. An absence in flesh and blood, as Sartre would have put it (1964), a retreat from the encounter, from existing fully—from the Latin, *absens*, present participle of *ab-sum*, “to move away from the other”, from fully being-with. Absence leads us to presence, from the Latin, *praesens*, present participle of *prae-sum*, “to be with the other”—thus presence is radically relational, tending toward the other, toward being together (Francesetti and Zarini, forthcoming). We could say that what the patient bears is what he does not have (a pain seeking the light with the other, but which is manifested as the absence of pain), which the therapist makes present by lending it his flesh. In clinical experience, “lending one’s flesh” is not a metaphor, but a concrete and simple experience, which lies in feeling something that does not already belong to me, but which comes from the field from which I emerge. ● Of course, putting it rather simply, we could say that the therapist feels something that does not belong to him—as it is pathic, it does not belong to anyone yet. But “lending one’s flesh” has a much more intense connotation, which underscores in a concrete sense the corporeal dimension of the phenomenon and is rooted in a phenomenological tradition of philosophy that enriches its semantics.

It is important to note how the pain is not something pre-defined and formulated, simply waiting to be revealed—as orthodox psychoanalysis would see it, with its theory of repression, where remedy lies in its revelation through interpretation. Here, instead, it is an urge that needs to find a form in the possibilities of the therapeutic encounter, an experience that is not yet formulated, which lies in the plane of the atmospheric and ineffable as it is pathic in nature. This is close to the conception of unformulated experience proposed by Donnel Stern (1997), which also nods to the atmospheric dimension through which what is not yet formulated emerges. The form that suffering will take depends on the conditions of therapy and on the background of the therapist himself, on what he himself brings to the session. For even the therapist brings his own pathos to the encounter, and with it his own embodied experience, which will deeply affect the ways in which the unformulated can find form in therapy.

The therapeutic situation is therefore a crucible for the emergence of the phenomenal field, which is the ecstasy (*ec-stasy*, or *coming up*) of the situation, where the therapeutic intentionalities that the patient and the therapist experience through their being absorbed by the pathic of the moment are put into motion. What happens to them, without their being able to choose it, is the actualization in the here and now of the intentionalities of the therapeutic encounter. The therapist becomes (or does not become) someone for the patient and the patient becomes (or does not become) someone for the therapist. It is not simply the repetition of something past, but the use of present possibilities to bring to light an unformulated—and hence unassimilated—experience that has never seen the light in any relationship and has remained unformulated as an absence in the flesh of the patient, persisting in space and time to the here and now. From the point of view of chronological time, the urge comes from past experience, but from the point of view of lived time, it comes from the here and now, emerging as a new potentiality that runs the risk of repeating—in a new way—what has already occurred. Bearing—suffering—seeks a clearing to exist (*ex-sist*, to *come out*), where it is taken in and taken up. Here we are describing, from a different epistemological perspective, and hence with different languages, openings and risks, the phenomena that psychoanalysis calls enactments, or acts of transference and countertransference (Jacobs T. 1986).

Thus, no psychopathology exists in the abstract, and no psychopathology pertains exclusively to the patient. From the very first instant of the encounter, the therapist is already participating in the atmospheric movement of suffering, contributing to it by the fact that he bears and is borne. The suffering that we can recognize emerges concretely in the here

and now, according to the possibilities and limits of the situation. It is manifested in the encounter as the phenomenon of absence in flesh and blood, which calls for presence (Francesetti 2012, 2015a). Therapist and patient emerge from a unique, never to be repeated force field that gives them form, enabling the actualization of the absences that have the potentiality to be transformed in the present moment. Suffering is pathos; it emerges in an atmospheric way and absorbs the patient and therapist in the phenomenal field from which they emerge, and which gives form to their experience. The session, therefore, is an occasion for the revival of pain in the forms of absence and for their transformation into presence.

5. “Listening as well to all that is missing / the harmony between all that is silent.”

**Diagnosis in the field perspective:
feeling what is calling out to be felt**

[...] I tell you
That I listen to
the thump of the pine cone and the acorn
The lesson of the wind
And the lament of your sorrow
With its sigh amassed on the pillow
A chant enchained that doesn't come out.

*Listening as well to all that is missing,
the harmony between all that is silent.*

Mariangela Gualtieri (2010, 128)

“I don't know why, it's out of the blue here... but I can't help but think of my mother.” Everything changes again. There's no ocean collapsing into a stone anymore, no more desire to run away, no more the feeling of being a coward in flight. Something is opening up and I'm ready, now I'm really ready and not just waiting for something to happen. I want to pursue this track now, whatever it takes, and I'm alert as can be. Anna goes on, “I don't know why she's come to mind... I went to therapy for years and worked extensively on my mother...”

“I don't know why either, but I'd like you to continue.”

Anna's father already had another family of his own and had abandoned her and her mother shortly after Anna was born. After that, her mother went through periods of very deep depression, which got particularly worse when Anna was a teenager. Her mother would often

say she wanted to end it all and the atmosphere at home was oppressive, tense, bleak, and silent. Anna managed to survive by detaching herself from that climate, working hard at school and having friends, leading in a certain sense two separate lives, one at home and one outside of home. When Anna was twenty, her mother fell into a particularly long and deep depression. After months of living with that abyss, Anna come home one day and found her mother wasn't there. She was found after four days of searching, hanged from a tree in the woods. Anna spent those anxious days of wait, and those that followed, at home alone.

I don't feel a weight anymore now, I feel pain. Anna also feels pain. We feel it together. I feel we are together in that pain and it is helping us. I ask her what kept her going in that period. "Looking forward. I never stopped looking forward, forward to the future. The day they found her was terrible, but it also marked the end of a nightmare and the start of freedom." I feel the truth of what she's saying and would like to say, of course it did, that she was finally free and the time had come to live her life. But when she says 'it marked the start of freedom', I also feel something else. I don't know what it is, but something hurts, something at the pit of my stomach again. I explore further, feeling my way around again. I ask her who was with her in that period. Lots of people, she says, but nobody who had anything to do with the life she led with her mother that was off-limits. It seems to me that the death of her mother was the slice of the knife that freed her from an oppressive weight, like the tethering that holds down a hot-air balloon, which when cut finally frees the balloon to float up to the sky. A compelling image that has supported her in these twenty years since her mother's suicide, a freedom legitimised over years of therapy.

So what's missing? What's eating at me? Completely unexpectedly, I start thinking of my own father and his death, and at what kept me going when at nine years of age life was upended and overturned by a tsunami. The terror of that moment comes back to me, but also what came afterwards, the years in which I re-found my father. Immediately, what kept me going was my adolescent future, life drew me forward and I wanted to follow it, but then it was fundamental that I found a way to keep him in me.

"Looking ahead kept you going, of course... What do you keep in you of your mother? What do you have of her? Anna stops. Time itself comes to a stop for a moment, suspended. Her eyes look at me as though they were seeing me for the first time, her pupils wide open. She's looking at something she's never seen before. My question has placed her in front of a new landscape. "I don't know, I've never thought about it... After the funeral I fled and closed the door on that life. I already knew the man who

would later become my husband, I had my studies, my friends. My life started over, finally happy and free."

Time is flowing now without obstacles.

"What are those tears that are flowing down your face? They seem new, different from the ones before..." "Yes... I don't know... I feel sorry for my mother. I don't know, I feel sorry for her... I think, maybe, I miss her..." Anna is now crying with a new freedom, and with new tears.

Referring readers to the previous literature for a discussion and insight into diagnosis in Gestalt Therapy, (Francesetti and Gecele 2009; Francesetti 2012; Francesetti, Gecele and Roubal 2013; Roubal, Gecele and Francesetti 2013; Roubal, Francesetti and Gecele 2017), here I will focus solely on a fundamental point, which is that if suffering emerges in the therapeutic situation in forms of absence in the encounter, then diagnosis is the process of evaluating those absences and their calling for presence. The diagnosis we are speaking about here is not the extrinsic diagnosis of measuring what the patient relates, does and is against an external grid of reference. Such diagnosis (for instance the DSM or the ICD) is often necessary to support the therapeutic process and the clinical practitioner needs to know its procedures, as well as its limits. The greatest risk involved with extrinsic diagnosis is that of assuming its truth uncritically, or rejecting it altogether without careful and critical deconstruction and contextual relativization—something which both, “preconceived” positions fail to do. Instead, what we are speaking of here is intrinsic, or aesthetic, diagnosis, involving an evaluation of the quality of the flow of experience in the here and now of the session. Aesthetic diagnosis is, first of all, an evaluation of the emergent phenomenal field and hence of the pathic and atmospheric that appears in the therapeutic situation. Taking in the movement of the flow of experience is already a contribution to its taking on form.

The attitude that makes this type of diagnosis possible¹⁰ requires the therapist, to begin with, to be attuned to his bodily experience, as though the body were a sort of seismograph able to intercept even the slightest movement in the field, and to carefully listen for the resonances in him (Francesetti 2019, in press), the fount of aesthetic relational knowledge (Spagnuolo Lobb 2018). He prepares himself for not knowing what will happen, what alien will emerge, and so he waits, tolerating a profound uncertainty (Staemmler 1997, 2006). To do this, he leans on his own corporeality and his breathing, in a form of epoché (Bloom 2009). He is open and attentive to anything that could emerge in his own lived

¹⁰ For a description of the skills implied in this process, see Francesetti (2019, in press), Francesetti and Roubal, forthcoming.

experience, curious about any sensation or image that might appear. He is willing to be moved, even by something he least expects, to find himself in a landscape in which he is thrown by no choice of his own. He is aware that any sort of definition he might give to what emerges will only be provisional, imprecise and by its nature incomplete. He will not even know whether what is perceived belongs to the therapist or the patient, and the greatest risk here is that of attributing it to either one or the other, when very often attributing it is of little importance. It is fundamental that the therapist has undergone therapy himself to be aware of the way in which he places his own suffering in the field, but the emphasis on the need to distinguish what pertains to the patient and what pertains to the therapist belongs to an epistemology in which two defined subjects co-create their experience. Here I want to focus on the therapeutic situation as a setting in which the patient and the therapist co-emerge, where it is not always possible to distinguish what pertains to the therapist and what pertains to the patient, because what emerges is a function not just of their subjectivities, but of the uniqueness of the situation and the Gestalt Therapy principle that the whole is more than the sum of its parts. What is more important, clinically and ethically, is that it is not attributed strictly to either one or the other and that a process is supported enabling the original actualization of suffering and its transformation.

In emerging, the pathic is indefinite, synaesthetic, atmospheric, challenging all definition, including verbal definition (Griffero 2014). It is not about discovering something preformed, but about taking in what is without form and tends to take on form in the situation.

What is drawn out by the therapy situation and by transformation processes are those parts of the patient's experience that have yet to find form and place in a relationship. As such, what is relevant often emerges as out of place, as disturbing, uncanny, as atonement, as what was excluded from the relationship cannot but be branded as unexpected, as a disquieting guest, the alien *par excellence*. But an alien that has always lived with us. The therapist will feel it as something he would rather not feel, something out of place, as we said. For instance, it may be a feeling of boredom or anger, of aversion or attraction, or sleepiness or inadequacy, of a solitude he wished he did not have, which he tries to dismiss, or of disturbance or interference. It is a quality that often comes with the emergence of something that has long remained in the shadows, ineffable and formless, which presses to come to light. These are the pointers of greatest interest and potential for transformation in the therapeutic situation, and the therapist needs to abstain from attributing his own resonances to the patient, something he instead does every time he

rushes to the conclusion that the patient is wearisome, boring, annoying, long-winded, impossible, likeable, disagreeable, disgusting, attractive, seductive, manipulative, etc. When it does happen, he needs to realize and distance himself, and let the boredom, annoyance, long-windedness, etc. float in the air, without prematurely, and defensively, attributing it to the patient. This is not just a clinical matter, as since the relationship is an asymmetrical one, in terms of power and responsibility, it is also an ethical matter.

Thus, usually, there is no hidden truth to be revealed, rather it is about taking in and giving form to the drives that follow the intentionalities for contact at play. To perceive is already to give shape to the shapeless, and here we see a concrete relational application of Heisenberg's uncertainty principle, whereby it is impossible to observe without modifying what is observed. In the indefinite of the atmospheric, there is already a movement (or a suffering for its absence, which in any case presupposes the taking in of a movement in its absence), for there is an expectant waiting that implies a more or less intense tension. It is how we experience the drive of emergent intentionality, which moves towards its evolution. That movement is neither random nor driven by a rationale external to the situation; it follows an intrinsic criterion of creating a good form—what is good, beautiful, with grace and energy, elegance, fullness and presence is felt, without the need for an external rule and without the need for interpretation (PHG, Ch. IV, § 13; Bloom 2003; Robine 2006; Spagnuolo Lobb 2013; Francesetti 2012; Tellenbach 2013). “There are two kinds of evaluation, the intrinsic and the comparative. Intrinsic evaluation is present in every ongoing act; it is the end directedness of process, the unfinished situation moving towards the finished, the tension to the orgasm, etc. The standard of evaluation emerges in the act itself, and is, finally, the act itself as a whole” (Perls, Hefferline and Goodman 1994, 65–66). Taking in that flow and, inevitably, at the same time supporting the process that gives it form is diagnosis and therapy in one and the same act. As such, it is not the patient that is evaluated and treated, because what is evaluated is the process of figure formation, the *Gestaltung*. That is from where the term “Gestalt Therapy” comes, because what is supported is the formation of the *Gestalt* (Francesetti 2012, 2015a).

As mentioned at the start, we can differentiate intrinsic, or aesthetic, diagnosis from extrinsic diagnosis, in both its semeiotic and hermeneutic forms (Francesetti 2015a). Semeiotic diagnosis is based on the use of a code to make sense of the signs that are observed—street signs and the DSM are both semeiotic, albeit with different degrees of complexity. Hermeneutic diagnosis uses a theory, or a narration, to make sense of what is observed. Different theories exist, for instance, to explain narcissism,

and I can make sense of what happens in a therapy session by calling on those theories and finding direction through them. Aesthetic diagnosis instead lies in the intrinsic evaluation of what emerges, which requires specific competence to be able to take in and appreciate the pathic dimension of the experience and make use of it in therapy. Extrinsic (or comparative) diagnosis and intrinsic (or aesthetic) diagnosis are not mutually exclusive alternatives. Typically, the therapist will move, more or less intentionally, between the one and the other (Roubal, Gecele and Francesetti 2013). Extrinsic diagnosis requires knowledge of codes and theories and can be made even from a rather detached position in the relationship, with all the iatrogenic risks that can entail, such as the crystallizing of the suffering, the objectification of the patient, leaving her on her own, yet again, and the exercise of power, which, in such conditions of vulnerability, can be asymmetric and violent. Aesthetic diagnosis instead requires deep-rooted engagement in the encounter, which itself entails a number of iatrogenic risks, in particular the blurring of boundaries. Nevertheless, it is the road that leads us to take in how what is not formulated calls out to emerge and be transformed in the encounter: “Every being silently clamours to be read otherwise” (Weil 2004, 43).

Diagnosis is therefore a delicate process that calls for great skill, awareness, and care in dealing with clinical and ethical aspects. The therapeutic situation is the delegated arena for the revival of suffering. As such, it is a privileged situation for suffering to repeat itself—giving rise to retraumatization—and be transformed—offering cure.

6. “There is a crack in everything, that’s how the light comes in”. Therapy in a field perspective: modulating the presence of the therapist

*We asked for signs
The signs were sent
[...]
Ring the bells
That still can ring
Forget your perfect offering
There is a crack, a crack in everything
that’s how the light comes in
that’s how the light comes in
Leonard Cohen, Anthem¹¹*

¹¹ From the album *The Future* (1992).

"I never realized it... my life was beautiful, but I ran away from a nightmare without ever looking back. Actually, no... I did look back, but I only ever saw the nightmare I had left behind. Sometimes I dream with dread of my mother coming back and me running away. Now I feel something else..." Anna can look at me now without turning away; it's the same for me. Both of us lean forward, drawing nearer to each other. There's pain, a good pain, which smells of something new. "What have you learnt from your mother?" Anna smiles, and a gush of joy illuminates her face. "Um... lots of things, I think... I've never actually thought about it. I learnt to dance with her. We would put music on and she'd dance—we'd dance together, like two crazy fools, but it was wonderful. She loved Leonard Cohen and would always listen to his music. They were beautiful moments. Yes, my passion for music and dancing came from her... and drawing, too, she loved drawing—she was really good—and I like it, too! I draw and dance with my son so much, but I never stopped to think that it came from her." The atmosphere is different now. It's all here, now. Levity is no longer someplace else. It has emerged from that same world that was so grim and grave before, now so intense, painful and joyful all at the same time. "What was a song she liked, for instance?" Anna pauses thoughtfully. "I can remember a Leonard Cohen song, Anthem I think, which goes, 'There is a crack in everything... that's how the light comes in'..." "That's how the light comes in..."

With those words, a new awareness emerges, a new pain takes shape, a different light shines on the landscape, transforming it. Anna cries and smiles, showing a profound gratitude—for herself, for me, for her mother, for the singer of that song, for the group, moved with emotion like us, for being able to live this moment, for life. I take Anna's hands in mine and she grasps them. Without any need for words, we hug each other. Anna sobs, and a profound tenderness takes over me. We stay there as long as necessary, then say goodbye.

The group, touched and moved, waits, and then shares the experiences it went through during the work.

Thus we have posited our theoretical premises. Therapist and patient come together—in the sense that they find themselves and come to exist—in the therapy setting. A phenomenal field emerges, perceptible in an atmospheric way, and they are moved by the pathic following the intentionalities at play, within the limits and the possibilities implied by the situation. The therapist is open to being absorbed by the emergent atmosphere, which transports him into an auroral landscape which at first is undefined, and he prepares himself to take in the resonances in him,

focusing in particular on those most alien and disturbing—the atupon. We have seen how taking-in is itself an act that gives form and hence how it is therapeutic for the unformulated experience that urges to see the light. But it is not enough. Here we are still hanging in the balance, on the fine line between re-traumatization and cure. The crucial step is made here. When a resonance emerges, the therapist inevitably risks putting it into circulation by bringing it into play in a re-traumatizing way (Francesetti 2019, in press; Jacobs L. 2017). It is a risk that is inevitable, as avoiding it would mean abstracting oneself from the relationship, which carries no lesser risk. What step will put the therapist on a different road to repeating, albeit in a new way, the trauma or the same old game? The question is a central one, because while it is true that as long as we are absorbed by the phenomenal field, by the pathic that moves us, we are open to the possibility of therapy, it is not itself the “cure”, but only the start of the journey. For now, we are simply in the landscape where suffering becomes present, which is no small thing, but we risk simply reviving it and etching it even more deeply in memory. To describe the move to be taken, we can say that the therapist takes in the resonance, the way in which he is moved, but does not identify with it. Instead he opens up a breach by being curious, by recognising that something alien is knocking at the door, emerging and coming in, in a shadowy, twilight world where something is happening. The therapist is awakened by that knocking, but does not prematurely attribute a meaning to it, or take it as a defined and definitive truth about the patient, himself or the situation. He waits and hesitates,¹² from the Latin, *haesitare*, to hold fast. He stops, uncertain and perplexed. And in that non-doing, that holding fast in suspension, letting what happens happen and happen to him, the therapist does something important: he intentionally lends himself to the situation, letting the situation “use” him for the transformation processes at play to unfold (Yontef 2005). His awareness is an element that makes the difference. It means he is aware of what he feels, of what is happening to him, and turns to it with curiosity, taking in what will be the first impulse towards doing or saying something, without acting on it or dismissing it. Even if what comes is out of place, an annoying atupon he would rather discard, he holds onto it—the stone the builders reject will become a cornerstone. There are two risks here at this moment: that the therapist acts out the resonances he feels without being aware of it, or that he discards them as disturbances. In the first case, he will put the theme of suffering back into circulation; in the second he will inhibit an unformulated part of the field from emerging through him.

¹² On the relationship between hesitation, experience and aesthetics see Tagliapietra (2017).

Resonance is a vibration corresponding to “something” that is *present* and at the same time *neglected* in the phenomenal field, which seeks flesh to come to light. Thus the therapist does not dismiss the resonance, he lets it be with a sense of curiosity, asking himself “what do I feel in feeling this?”, “what is the sense of what I feel?”, and what will generally happen is that something will emerge around the edges of the resonance, after the first impulse. It might be a feeling about that resonance, or an image, a memory, a desire, etc. At first, for instance, he might feel disinterested in the story of a tragic accident that happened to the patient. If he stops and pays attention to that disinterest he feels to be out of place, and does not let himself be overcome by the sense of inadequacy that can arise, but instead values the feeling and asks himself what it can mean, after a while a sense of sadness may emerge at not managing to be closer to the patient in the experience. At that point, he can try to share that sadness and perhaps explore his disinterest with the patient, probing together with her the landscape in which they have come together and noticing how by exploring it, it changes. This step towards the self-disclosure of what the therapist is experiencing is both an important and delicate one, because it supports the process of suffering becoming present, which is necessary but also runs the risk of re-traumatization. A criterion I suggest here is to not make the resonance one feels explicit until it is all one feels—the terrain needs to be left to develop a bit by biding one’s time and being curious, by dwelling, waiting and hesitating; a curious attitude is needed, which focuses on what is happening without identifying with it completely. Borrowing the words of Jean-Luc Marion once again, the therapist lends his flesh to the other so that what is borne—the suffering—can emerge. The patient has deserted his painful flesh, leaving behind an absence that only the other—in this case the therapist—can dwell in by lending his own flesh. But he does not lend *all* of his flesh. If he did, he would only be acted upon and would lose sight of the game that is being played out and the margin of freedom there is to choose whether and how to play it. Therefore, being absorbed by the pathic of the situation is inevitably the first event of each encounter. The therapist then takes in his being absorbed and the resonances in him, neither dismissing them nor acting on them, but noticing them with curiosity while waiting for something else to emerge. Suffering seeks other flesh that makes room for the unformulated pain that it bears, and when it finds it in the flesh of the therapist, the pain will be felt anew and in a new way, for it emerges here together with the pleasure that something good is happening. Again, in the words of Marion (2007, 119): “By pleasure, we understand my reception by the other’s flesh; [...] Inversely, by pain, we understand the resistance of the other’s

flesh to my own (or even the resistance of mine to hers), such that it contests or refuses my own flesh”.

The therapist’s realization of what is happening to him and his incomplete identification with it marks the shift from the phenomenal field absorbing the therapist to the *phenomenological field* (Francesetti 2019, in press). That shift is marked by the introduction of a greater degree of freedom in the situation, for which the therapist is able to realize and verbalize—within the limits inherent to language, as we discussed earlier—what is happening. Now the therapist is not just absorbed by the field, but he becomes aware of how he is absorbed, of what happens, and of the game that he is called upon, and that he himself calls, to play. Here he can make choices, as there is sufficient freedom to do so. The first choice is to wait for something else to emerge and to feel free not to rush into action, to give himself time to feel what call is calling. Therapy work in this perspective is the modulation of the therapist’s presence and not the changing of the patient (Beisser 1970). Only at that point can an exploration of the situation begin and with it the experiencing of new ways of encountering—only now that the old game has been actualized can a new degree of freedom be introduced that is sufficient to take up what is borne without reproducing it. Following Sartre’s lead (2007), something can always be done with what is done with us. For a description of the therapeutic steps involved in this perspective (which I call HARP) and the skills necessary, see Francesetti (2019, in press).

It should be clear by now that the paradigm I am describing involves a major shift from the model in which the therapist is an expert who acts on how the patient functions to modify him and make him better (the medical or mono-personal paradigm). But neither is it equivalent to a co-creation paradigm in which the therapist and the patient interact and together effect change (the co-creation or bi-personal paradigm). What we are proposing is a different scenario, which I call a *field paradigm*, underpinning a *field-based clinical practice* where the therapist is at the disposal of the transformative forces in the field, which transcend both him and the patient. His contribution lies in being sensitive to what moves him, in taking in the ways in which he himself is absent in the situation and modulating his presence to enhance it—he is the Socratic midwife, not for the patient but for what is gestating in the field; he is the flesh through which absence takes on form and becomes presence. Absence is the way in which pain that cannot be formulated is borne, hence it is suffering. The moment in which the therapist becomes present to the absence, the pain is no longer absent and can unfold, taking on new life in the flesh of both, and both become more alive. Mortified flesh is revived. Silenced flesh can

sing once more. We see an enhancement of being, as Simone Weil would have put it (2002). Bearing witness to this process is the ephemeral yet eternal beauty that emerges in the encounter.

The field paradigm enables us to include, study, and understand among the factors of therapy not just the direct action of the therapist and interaction between the patient and therapist, but also environmental and contextual factors and the effect of different settings (for instance how therapy can differ if conducted in one's own private practice or in a public service where one works in a team, or the difference between a group session and an individual setting), and even the use of altered states of consciousness and the use of psychoactive substances that amplify pathos, driving the unformulated to emerge with greater force and find space in the therapeutic situation (Carhart-Harris et al. 2014). The other vector that emerges from a field perspective, but which transcends the purposes of this chapter, is the significance of the cultural and social climate in the formation of social psychopathologies, or phenomena experienced and acted on individually, which are widespread and normal in a particular social context (Salonia 2013). Being aware of the spirit of the times and how it moves us is the only chance we have of acquiring a sufficient degree of autonomy to act freely within the restraints of the situation, and thus be present and alive.

7. "We have a soul at times". Will beauty save the world?

*We have a soul at times
No one's got it non-stop,
For keeps.*

*Day after day,
Year after year
May pass without it.
[...]*

*Joy and sorrow
Aren't two different feelings for it.
It attends us
Only when the two are joined.
We can count on it
When we're sure of nothing
And curious of everything.
[...]*

*We need it
But apparently*

It needs us

For some reason too.

Wisława Szymborska (2005)

If suffering therefore manifests itself in the clinical encounter as pathos and atmosphere, colouring and permeating the space and time of the encounter, then do different atmospheres exist for different types of suffering? In other words, is it possible to outline a typology of psychopathological atmospheres? It would appear the answer is yes, and such a typology would become a description of the perceptive qualities of the different types of absences that can emerge in therapy sessions. It is certainly not hard to distinguish the atmospheric qualities of a depressive field from an anxious field. In a depressive field, for instance, the air is gloomy and grave, space dilates, and something pushes or pulls bodies down (Francesetti 2015b); whereas in an anxious field, time typically speeds up, space contracts and something draws us upwards. If the anxiety is the kind associated with panic, bodily organs are pushed to fore in their dysfunction, and a mortal danger winds through the air, paralyzing us (Francesetti 2017); whereas with anxiety of the obsessive kind, space-time rolls into siege time, where things close in, pressing against us, time becomes linear, uniform motion and wait becomes alarm and the control of boundaries (Francesetti 2017). In a paranoid type of psychotic field, the air can become suspended in anguishing expectancy, something is about to happen or arrive but we do not know when or from where, and the sense of alarm is an incessant hissing from which it is essential not to be distracted (Francesetti and Spagnuolo Lobb 2013). We could go on for every single type of suffering and expand the descriptions to make them increasingly more detailed and evocative. Every clinical atmosphere is the epiphany of a way of bearing pain on oneself, of suffering, of sketching out landscapes that convey an unspeakable experience that seeks to exist through the encounter and the opening of the flesh. Every atmosphere is singular—both unique and typical at the same time—just as human beings are. Such an exploration could perhaps support both the extrinsic and intrinsic diagnostic process, potentially constituting a point of intersection between the two methods by focusing on an evaluation of what emerges in the encounter. And it could also perhaps steer the clinical practitioner towards the call that the specific actualized field bears with it, thus pointing the way for therapy to follow.

There is one atmosphere, however, that deserves a privileged position in our discussion, as it is an atmosphere that emerges as a sign that a clinically significant transformation is underway (Francesetti 2012). Whatever the psychopathological field we start from, when unformulated

pain is taken-in in the flesh of the therapist, a shift can be felt in the situation towards an opening that is touching and moving and felt to be good and beautiful. It is a particular quality of beauty that is neither objective nor subjective, but rather emerges precisely as an atmosphere that is clearly perceptible to all present when doing group work, when something beautiful appears and floats in the air. When it emerges, our attention becomes more acute, fatigue vanishes, time slows down, space lightens up and, in varying degrees of intensity, surprise, expectation, and wonder appear, just like when watching a new baby being born—an atmosphere that is perceptible perhaps in certain Italian Renaissance paintings of the nativity. It is not a beauty one wants to possess, however; rather it is “a fruit we look at without trying to seize it” (Weil 2002, 150). A beauty that stirs us and *moves us together*, that touches us deep down and has the quality of the sacred—in the etymological sense of a fenced, protected and separated place in which an event is happening (Galimberti 2012), where event is understood in Maldiney’s terms (2007). Yet, it is not just pleasure, but rather a pleasure that at the same time strikes the chords of pain. Or, to put it in other words, the pleasure we feel when pain, after infinite and inenarrable voyages, finally finds its landfall in the encounter. In this sense, the emergent beauty of the encounter is the epiphany of the therapeutic transformation, and although it is ephemeral as an atmosphere, it leaves a lasting trace on the embodied. The relationship between pain and beauty is a theme that permeates the works of Dostoevskij (1992, 85):

Madame Yepanchina studied Nastasya Filippovna’s portrait for some time in silence [...]

“Does that kind of beauty appeal to you?” she suddenly addressed the Prince.

“Yes... that kind...” the Prince replied, with a certain effort.

“You mean just that kind?”

“Just that kind.”

“Why?”

“In that face... there’s a great deal of suffering...”

In another passage, Ippolit asks the Prince tauntingly and ironically what kind of beauty will save the world:

“Is it right, Prince, that you once said the world would be saved by ‘beauty’? Gentlemen,” he suddenly shouted loudly to all and sundry, “the Prince says the world will be saved by beauty! And I say he has playful notions like that because he’s in love. Gentlemen, the Prince is in love [...] What beauty is going to save the world?...” (Dostoevskij 1992, 402).

I will leave that question open here. We all know we do not know the answer, but I would at least like to change its tone to be neither a joke nor a provocation, but a serious question.

And I would go so far as to say that in clinical work, when such atmospheric beauty appears, coming to light and illuminating us in turn, a small piece of the world is, perhaps, saved.

References

- Alvim Botelho, Monica. 2016. "Id of the Situation as the Common Ground of Experience." In *Self: A Polyphony of Contemporary Gestalt Therapists*, ed. by Jean-Marie Robine, 317-336. St. Romain-La-Virvée: L'Exprimerie.
- Barron, James W., ed. 1998. *Making Diagnosis Meaningful: Enhancing Evaluation and Treatment of Psychological Disorders*. Washington DC: American Psychological Association.
- Bateson, Gregory. 1979. *Mind and Nature. A Necessary Unity*. New York: Dutton.
- Béguin, Albert. 1939. *L'âme romantique et le rêve*. Paris: José Corti.
- Beisser, Arnold R. 1970. "The Paradoxical Theory of Change." In *Gestalt Therapy Now: Theory, Techniques and Applications*, eds. by Joen Fagan and Irma Shepherd, 77-80. Palo Alto: Science and Behavior Books.
- Bloom, Dan. 2003. "'Tiger! Tiger! Burning Bright'. Aesthetic Values as Clinical Values in Gestalt Therapy". In *Creative License. The Art of Gestalt Therapy*, eds. by Margherita Spagnuolo Lobb and Nancy Amendt-Lyon. Wien-New York: Springer.
- 2009. "The Phenomenological Method of Gestalt Therapy: Revisiting Husserl to Discover the Essence of Gestalt Therapy." *Gestalt Review* 13, 3: 277-295.
- 2013. "Situated Ethics and the Ethical World of Gestalt Therapy." In *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*, eds. by Gianni Francesetti, Michela Gecele and Jan Roubal, 131-148. Milano: Franco Angeli.
- Borgna, Eugenio. 1988. *I conflitti del conoscere*. Milano: Feltrinelli.
- Böhme, Gernot. 2010. *Atmosfere, estasi, messe in scena. L'estetica come teoria generale della percezione* (2001). Milano: Marinotti.
- 2017. *The Aesthetics of Atmospheres*. New York: Routledge.
- Bracken, Pat et al. 2012. "Psychiatry Beyond the Current Paradigm." *British Journal of Psychiatry* 201, 6: 430-434.

- Buffoni, Franco, ed. 2016. *Italian Contemporary Poets. An Anthology*. Roma: FUIS.
- Carhart-Harris, Robin et al. 2014. "The Entropic Brain: A Theory of Conscious States Informed by Neuroimaging Research with Psychedelic Drugs." *Frontiers in Human Neuroscience* 8, 20.
- Cary, Joseph. 1993. *Modern Italian Poets (Saba, Ungaretti, Montale)*. Chicago-London: The University of Chicago Press.
- Chomsky, Noam. 1968. *Language and Mind*. New York: Harcourt, Brace and World.
- Conrad, Klaus. 1958. *Die beginnende Schizophrenie*. Stuttgart: Thieme.
- Costa, Cristina et al. 2014. "Phenomenology of Atmospheres. The Felt Meanings of Clinical Encounters." *Journal of Psychopathology* 20, 4: 351-357.
- Damasio, Antonio. 2012. *Self Comes to Mind. Constructing the Conscious Brain*. New York: Vintage.
- Dostoevskij, Fjodor. 1992. *The Idiot* (1869). Oxford-New York: Oxford University Press.
- Francesetti Gianni. 2012. "Pain and Beauty. From Psychopathology to the Aesthetics of Contact." *British Gestalt Journal* 21, 2: 4-18.
- 2015a. "From Individual Symptoms to Psychopathological Fields. Towards a Field Perspective on Clinical Human Suffering." *British Gestalt Journal* 24, 1: 5-19.
- 2015b. *"Absence Is the Bridge Between Us". Gestalt Therapy Perspective on Depressive Experiences*. Siracusa: Istituto di Gestalt HCC Italy Publishing Co.
- 2017. "'Suspended from Shaky Scaffolding, We Secure Ourselves with Our Obsessions'. A Phenomenological and Gestalt Exploration of Obsessive-Compulsive Disorder." *British Gestalt Journal* 26, 2: 5-20.
- 2019. "The Field Perspective in Clinical Practice: Towards a Theory of Therapeutic Phronesis." In *Handbook for Theory, Research and Practice in Gestalt Therapy* (2nd edition), ed. by Philip Brownell. Newcastle upon Tyne: Cambridge Scholars Publishing, in press.
- Francesetti, Gianni and Gecele Michela. 2009. "A Gestalt Therapy Perspective on Psychopathology and Diagnosis." *British Gestalt Journal* 18, 2: 5-20.
- Francesetti, Gianni, Gecele, Michela and Roubal Jan. 2013. "Gestalt Therapy Approach to Psychopathology." In *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*, eds. by Gianni Francesetti, Michela Gecele and Jan Roubal, 59-78. Milano: FrancoAngeli.

- Francesetti, Gianni and Spagnuolo Lobb Margherita. 2013. "Beyond the Pillars of Hercules. A Gestalt Therapy Perspective of Psychotic Experiences." In *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*, eds. by Gianni Francesetti, Michela Gecele and Jan Roubal, 393-431. Milano: Franco Angeli.
- Francesetti, Gianni and Roubal Jan. *Towards a Field-based Clinical Practice: Paradoxical Theory of Change reconsidered*. Forthcoming.
- Francesetti, Gianni and Zarini Paola. *Absence, Présence*. Forthcoming.
- Freud, Sigmund. 1970. *Das Unheimliche* (1919). *Studienausgabe*, Bd. IV: 241-274. Frankfurt: Fischer.
- Galimberti, Umberto. 2012. *Cristianesimo. La religione dal cielo vuoto*. Milano: Feltrinelli.
- Gleick, James. 1987. *Chaos: Making a New Science*. New York: Viking Penguin.
- Greenberg, Jay R. and Mitchell Steve A. 1983. *Object Relations in Psychoanalytic Theory*. Cambridge, MA: Cambridge University Press.
- Griffero, Tonino. 2014. *Atmospheres. Aesthetics of Emotional Spaces* (2010). Farnham: Ashgate/Routledge.
- 2016. *Il pensiero dei sensi. Atmosfere ed estetica patica*. Milano: Guerini.
- Gualtieri, Mariangela. 2003. *Fuoco centrale e altre poesie*. Torino: Einaudi.
- 2010. *Bestia di gioia*. Torino: Einaudi.
- Husserl, Edmund. 1931. *Ideas. General Introduction to Pure Phenomenology*. New York: MacMillan.
- Jacobs, Lynne. 2017. "Hopes, Fears and Enduring Relational Themes." *British Gestalt Journal* 26, 1: 7-16.
- Jacobs, Theodore. 1986. "On Countertransference Enactments." *Journal of the American Psychoanalytical Association* 34: 289-307.
- Jaspers, Karl. 1963. *General Psychopathology*. Manchester: Manchester University Press.
- Lingiardi, Vittorio et al., eds. 2011. *La svolta relazionale. Itinerari italiani*. Milano: Raffaello Cortina Editore.
- Maldiney, Henri. 2007. *Pensare l'uomo e la follia* (1991). Torino: Einaudi.
- Marková, Ivana S. and Berrios German E. 2012. "The Epistemology of Psychiatry." *Psychopathology* 45: 220-227.
- Marion, Jean-Luc. 2007. *The Erotic Phenomenon*. Chicago: University of Chicago Press.

- Masciandaro, Nicola. 2016. "Synaesthesia. The Mystical Sense of Law." *The Whim* (blog), 1/11/2016 (now available on academia.edu: https://www.academia.edu/30002887/Synaesthesia_The_Mystical_Sense_of_Law).
- Maturana, Humberto R. and Varela Francisco J. 1992. *The Tree of Knowledge. The Biological Roots of Human Understanding*. Boston: Shambhala.
- Mazzeo, Marco. 2013. "Introduzione." In Hubertus Tellenbach, *L'aroma del mondo. Gusto, olfatto e atmosfere*, 5-12. Milano: Marinotti.
- Menninghaus, Wienfried et al. 2015. "Towards a Psychological Construct of Being Moved." *PLoS ONE* 10, 6: e0128451. <https://doi.org/10.1371/journal.pone.0128451>
- Merleau-Ponty, Maurice. 2003. *Phenomenology of Perception: An Introduction* (1945). New York-London: Routledge.
- Metzger, Wolfgang. 1971. *I fondamenti della psicologia della Gestalt* (1941). Firenze: Giunti Barbera.
- Migone, Paolo. 2013. "Presentazione del DSM-5." *Psicoterapia e Scienze Umane* 47, 4: 567-600.
- Minkowski, Hermann. 1927. *La schizofrenie. Psychopathologie des schizoïdes et des schizophrènes*. Paris: Payot.
- Morin, Edgar. 2008. *On Complexity*. Cresskill, NY: Hampton Press.
- 'Neill, Brian. 2008. "Relativistic Quantum Field Theory: Implications for Gestalt Therapy." *Gestalt Review* 12, 1: 7-23.
- Perls, Frederick S., Hefferline, Ralf F. and Goodman Paul. 1994. *Gestalt Therapy. Excitement and Growth in the Human Personality* (1951). Gouldsboro: Gestalt Journal Press.
- Philippson, Peter. 2009. *The Emergent Self. An Existential/Gestalt Approach*. London: Kama Books.
- Prigogine, Ilya. 1997. *The End of Certainty. Time, Chaos and the New Laws of Nature*. New York: The Free Press.
- Ratcliffe, Matthew. 2017. "Selfhood, Schizophrenia, and the Interpersonal Regulation of Experience." In *Embodiment, Enaction, and Culture*, eds. by Christoph Durt, Thomas Fuchs and Christian Tewes. Cambridge, MA: The MIT Press.
- Robine, Jean-Marie. 2006. *Il rivelarsi del sé nel contatto. Studi di psicoterapia della Gestalt* (2004). Milano: FrancoAngeli.
- ed. 2016. *Self. A Polyphony of Contemporary Gestalt Therapists*. St. Romain-la-Virvée: L'Exprimerie.
- Roubal, Jan, Gecele, Michela and Francesetti Giammi. 2013. "Gestalt Approach to Diagnosis." In *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*, eds. by Giammi

- Francesetti, Michela Gecele and Jan Roubal, 79-107. Milano: FrancoAngeli.
- Roubal, Jan, Francesetti, Gianni and Gecele Michela. 2017. "Aesthetic Diagnosis in Gestalt Therapy." *Behavioral Sciences* 7, 70. doi:10.3390/bs7040070.
- Rovelli, Carlo. 2016. *Reality Is Not What It Seems. The Journey to Quantum Gravity*. London: Allen Lane.
- Salonia, Giovanni. 2013. "Social Context and Psychotherapy." In *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*, eds. by Gianni Francesetti, Michela Gecele and Jan Roubal, 189-200. Milano: FrancoAngeli.
- Sartre, Jean-Paul. 1964. *The Words*. New York: George Braziller.
- 2007. *Existentialism Is a Humanism* (1946). New Haven: Yale University Press.
- Schmitz, Hermann. 2011. *Nuova fenomenologia. Un'introduzione* (2009). Milano: Marinotti.
- Schrödinger, Erwin. 1944. *What Is Life? The Physical Aspect of the Living Cell*. Cambridge, UK: Cambridge University Press.
- Sichera, Antonio. 2001. "A confronto con Gadamer: per una epistemologia ermeneutica della Gestalt." In *Psicoterapia della Gestalt. Ermeneutica e clinica*, ed. by Margherita Spagnuolo Lobb, 17-41. Milano: Franco Angeli.
- Spagnuolo Lobb, Margherita. 2013. *The Now-for-next in Psychotherapy. Gestalt Therapy Recounted in Post-Modern Society*. Milano: Franco Angeli.
- 2018. "Aesthetic Relational Knowledge of the Field. A Revised Concept of Awareness in Gestalt Therapy and Contemporary Psychiatry." *GestaltReview* 22, 1: 50-68.
- Staemmler, Frank. 1997. "On Cultivating Uncertainty: An Attitude for Gestalt Therapists." *British Gestalt Journal* 6, 1: 40-48.
- 2006. "The Willingness to Be Uncertain. Preliminary Thoughts about Interpretation and Understanding in Gestalt Therapy." *International GestaltJournal* 29, 2: 11-42.
- Stern, Donnel B. 1997. *Unformulated Experience. From Dissociation to Imagination in Psychoanalysis*. Hillsdale: Analytic Press.
- Stern, Daniel N. 1985. *The Interpersonal World of the Infant. A View from Psychoanalysis and Developmental Psychology*. New York: Basic Books.
- Szymborska, Wisława. 2005. *Monologue of a Dog*. Boston: Houghton Mifflin Harcourt.

- Tagliapietra, Andrea. 2017. *Esperienza. Filosofia e storia di un'idea*. Milano: Raffaello Cortina Editore.
- Tellenbach, Hubertus. 2013. *L'aroma del mondo. Gusto, olfatto e atmosfera* (1968). Milano: Marinotti.
- The Boston Change Process Study Group. 2010. *Change in Psychotherapy. A Unifying Paradigm*. New York: W.W. Norton & Co.
- Vázquez Bandín, Carmen. 2014. *Sin ti no puedo ser yo. Pensando según la terapia Gestalt*. Madrid: Sociedad de Cultura Valle-Inclán, Colección Los Libros del CTP.
- Waldenfels, B. 2011. *Phenomenology of the Alien. Basic Concepts*. Evanston: Northwestern University Press.
- Weil, Simone. 2002. *Gravity and Grace* (1952). London-New York: Routledge.
- 2004. *The Notebooks* (1970). London-New York: Routledge.
- Yontef, Gary. 2005. "Gestalt Therapy Theory of Change." In *Gestalt Therapy History, Theory and Practice*, eds. by Ansel L. Woldt and Sarah M. Toman, 81-100. Thousand Oaks: Sage Publications.
- Zahavi, Dan. 2017. "Thin, Thinner, Thinnest: Defining the Minimal Self." In *Embodiment, Enaction, and Culture*, eds. by Christoph Durt, Thomas Fuchs and Christian Tewes. Cambridge, MA: MIT Press.

CHAPTER THREE

SURRENDER TO HOPE: THE THERAPIST IN THE DEPRESSED SITUATION

JAN ROUBAL

1. Introduction

“I say to myself: ‘It is so heavy!’ And in my mind, I say to the client: ‘Man, you should go to see a psychologist’. Then I realize the psychologist is actually there! ... In that situation, I forget I am a psychologist there.” This is what happened to one therapist facing a depressed client. It is however an experience shared by therapists, that they become someone other with a depressed client. They feel as though they are losing their professional competence. Sometimes, they can even lose their personal empathy for the suffering person in front of them. They get frustrated and irritated: *“It comes to my mind that probably it would be good if he commits the suicide that he has been talking about all the time... This comes to my mind!”*

How is it possible? What is happening to therapists in the situation with a depressed client? And, how can therapists manage their own experience in a way that could be helpful to the client who is suffering from depression? The following text explores these questions and strives to understand the specifics of therapists’ own experiences in the presence of a depressed client from the perspective of the present situation. The text invites you, who are reading it, to step out of the individualistic position of the therapist, client, or observer, and allow your understanding to be led by the perspective of the situation that transcends the individuals involved.

The text presents and attempts to adopt such a perspective as a new interpretation of a qualitative research study *Therapists’ in-session experiences with depressed clients: A grounded theory* (Roubal and Rihacek 2016). This study originally described how therapists’ experiences with depressed clients develop during the therapy session.

Based on the research results, it was later explained how psychotherapists cope with their experience when working with depressed clients (Roubal 2015). Illustrative quotes used in this chapter, selected from data used for the above-mentioned study, were gathered in interviews with psychotherapists who work with depressed clients. What is described here is the depressed way of the field organisation, whereas in practice, other kinds of dynamics, like anxiety or borderline tendencies, can often be involved and can influence the situation as well.

This text is not intended as an educational text to provide a consistent theoretical frame. Such concepts are comprehensively introduced in other chapters of the book. This text rather sums up my own clinical experience of working with depressed clients in a psychiatric hospital and in a private practice, and also from the collaborative exploration of the Gestalt therapy approach to psychopathology with my dear colleagues Gianni and Michela (Francesetti, Gecele and Roubal 2013; Roubal, Francesetti and Gecele 2017). My intention is to stay as close as possible to the experiential level of therapists' presence and to offer to readers my personal practice-based insights as inspiration. Therefore, theoretical terms are avoided where possible and a common, often metaphorical language is used, and readers are invited to find their own way of understanding this.

The text tries to explore the therapist's experience with a depressed client from three different perspectives: 1) the dynamics of the depressed individual, 2) the dynamics of the co-creation of depression, 3) the dynamics of the depressed situation itself. Each of these three perspectives is grounded in a different paradigm of change in psychotherapy, as detailed at the end of this chapter. The reader is invited to switch between these perspectives when reading the following text to explore the described phenomenon, as each of the perspectives offers another kind of understanding and other clinical guidelines.

2. Depression as a relational and field phenomenon

There are two basic assumptions for this text: First, depressed symptoms are seen as an individual expression of a specific relational experience. Second, the therapeutic situation is understood from the holistic process-oriented perspective of field theory.

According to the first assumption depression is understood as a suffering of a relationship (Francesetti and Roubal 2013). In depression, there is an existential need for the bond with another person, felt as an essential, powerfully embodied longing for the other. At the same time, the other is not felt as emotionally available and all efforts to reach the other

are discouraged by an omnipresent hopelessness. This together creates a pain, often described by depressed people as hurting more than pain from a physical injury.

People around a depressed person play their part in depressing processes, they co-experience the depression. The relational field organises itself in a depressed way, other people co-create the depressed organisation of the field and at the same time are influenced by it. As commonly observed, when in contact with a depressed person dialogue soon starts to slow down, time crawls and heaviness and tiredness falls on people around. People around the depressed one also contribute to the depressed field organisation. They are trying to get the depressed person out of their depression, make them move and stimulate their energy. They would say: "Come on, it is not so bad. Let's go somewhere, wherever you like. You will be in a better mood there". But the depressed person at that moment does not have the capacity to like something, to become active, and to pull themselves together. If the other person succeeds anyway and gets them out, the depressed person stays closed inside themselves, experiencing just that she is failing again and not fulfilling the expectations of the other. This relational experience further destroys their hope for a contact and makes them more and more depressed. After some time, the other person starts to become frustrated, loses the capacity to encourage and make the depressed one move, resigns themselves. Self-protectively they start to focus more on their own needs and occupy themselves with their own activities. The depressed person then experiences this as another abandonment that makes them even more depressed.

Therapists in the presence of a depressed client become part of the field that organises itself in such a relationally depressed way. They take part in its creation and experience it themselves. The therapist cannot stay out of the relationship in the therapeutic situation. It is not a contact between a distant healthy functioning professional and a depressively disordered client. The depression happens within the relationship here and now in the therapy situation. The therapist is the other who is present with the client at the moment, and at the same time is representing the general experience of the other in the client's life: the other, who is longed for and at the same time unreachable in the depression. The therapist and the client are in a way "depressing together" (Roubal 2007) as they both take part in the vicious circle of depression, in which the lack of energy prevents them from establishing a satisfactory, mutually energizing contact that would bring the lively experience of being with the other. They both participate in distorting contact processes by detaching themselves from the

constantly co-created fabric in-between that connects people to the world and to life (Francesetti and Roubal 2013).

However, the movement from one-person psychopathology to the co-created relational psychopathology is only the first step here. There is yet a second basic assumption for this text that goes beyond the co-creation paradigm. Therapists' experiences are described from a perspective of my current understanding of field theory as a way of perceiving the total situation (Lewin 1951), currently more specifically defined as the concept of a situation in Gestalt therapy theory (e.g. Wollants 2007; Robine 2011; Spagnuolo Lobb 2013; Francesetti 2015).

It is presumed here, that there is something new that appears in a meeting of people that transcends the persons involved. The whole of the situation is more than a sum of the people who meet each other. Moreover, the situation is ever changing from one moment to the next. This constant change, the flow of the situation, follows its own dynamics, and the involved people are transformed by it, they are functions of the situation. In our case, the client and the therapist are functions of the depressed situation, and so the therapist's experience can give us direct insights and understanding of the dynamics of the situation. Moreover, it provides us with hints on how the relational suffering can be healed.

Such a situational approach to psychopathology provides a theoretical background to this entire text. When the expression "depressed client" is used later, it is just a shorthand. In fact, it is meant to characterize a person who, as a function of the here-and-now situational field, becomes organized in a depressed way, experiences the suffering of the relationship, and whose embodied suffering is then observable as depressed symptoms.

3. Whirlpool of a depressed situation

A healthy situation follows a natural flow enabling the relational needs of the situation participants to be met. The process of the situation offers a chance for each of the participants to be seen by the other, to express themselves towards the other, to receive the response from the other, and to experience the energy generated in the mutually alive contact. The situation is grounded in the here-and-now and it naturally aims to the next moment. The relational needs of the participants give power to the flow, they channel it and give it a direction, which enables the situation to move naturally and smoothly to the next here-and-now.

In depression, the natural flow of the situation is blocked, or rather distorted in a specific way. The power of the relational needs is still present, but the other is unreachable. The flow of the situation does not

allow meeting the other, instead it deepens the abyss between the people. The flow turns around as a whirlpool and creates a deeper and deeper hole, the situation gets depressed more and more. What are the characteristics of the whirlpool dynamics?

First, the movement down is a characteristic of depression. People “fall down” into a hole, into a depression, and the falling affects all components of their life. There is a decrease in mood and energy, loss of initiative and joy. However, there is not only the movement down, but also a restriction, a narrowing, which presents the second component. Activities and contacts become restricted, the scale of coping strategies become narrowed. Thirdly, there is a cyclical movement, often described as a *vicious circle* from the perspective of different psychotherapy approaches. The decreased ability of the depressed person to cope with their own mental and physical processes, as well as with external demands, leads to more frequent failures, a subsequent deepening of the depressed state and a further decrease in the capacity of the person. When we put together these three kinds of movement – falling, narrowing and turning around in a vicious circle – we get an image of a “whirlpool of depression”, which distorts the natural flow of the situation and forms the dynamics of the depressed situation.

4. The therapist being pulled down

The whirlpool pulls therapists down as well. They experience self-doubt, feelings of failure, helplessness, hopelessness, and also overall dullness and tiredness. They lose the ability to differentiate their own experience from their client's, they miss a broader perspective. In general, they feel as though they are being pulled down into the depressed experience themselves: *“It happens to me [...] that I fall into it somehow. Down. I am saying to myself: ‘This is so terribly hopeless. It’s no wonder at all that there is no way out’”*.

Therapists experience sadness, anxiety, emptiness, fear for a client, and fear of their own failure. Their experience merges with the experience of their clients, and so they are experiencing symptoms of depression themselves. They perceive a loss of ability to think clearly and to concentrate. On a bodily level, they feel stiffness, heaviness, weakness, and exhaustion: *“When I am sitting with him there, I feel a terrible tiredness. [...] As if I will not be able to raise my hand anymore”*. Therapists feel overwhelmed by a feeling of hopelessness: *“Nothing has any meaning and nothing works”*. All these experiences felt by therapists reflect the pulling down power in the whirlpool of the depressed situation.

It is not only the therapist who gets pulled down by the whirlpool of the depressed situation, it is also a common experience for other people who meet the depressed person. A phenomenon called “the contagiousness of depression” (Coyne 1976a; Joiner and Katz 1999) describing the appearance of emotional and behavioural expressions of depression, such as low mood, gloominess, anhedonia, pessimism etc., in the other who stays in the presence of the depressed person, was researched widely in different populations and different settings. Signs of depression were registered even after a short and often indirect contact with a depressed person and “the contagiousness of depression” was found in longer relationships, either with roommates or intimate partners.

The metaphorical description of “contagiousness of depression” seems to be another way of depicting the pulling down power of the whirlpool of depression. From the perspective of the situation, the contagion does not appear as a transmission from the depressed person to another person, rather the depressed situation itself is contagious for all the participants. As commonly observed, a dialogue with a depressed person immediately starts to slow down, time seems to crawl, and heaviness and tiredness falls on people around. The relational field organises itself in a depressed way that can be observed in experiences of people involved in the situation.

5. The therapist trying to escape

People are not only pulled down experientially by the whirlpool of depression. They also fight the pulling down power and try to escape from it. This could be an explanation why interpersonal reactions elicited by the meeting with a depressed person were identified as two polar basic reactions: depressed mood induction and rejection (Coyne 1976b). The psychotherapeutic literature describes a large scale of common therapist interpersonal reactions to working with depressed clients from being “sucked in” to being “angry” or “annoyed” (Levenson 2013). Different kinds of therapist experiences are often conceptualized into polarities. There is a basic tension between therapists’ professional stance and their personal emotional response to a suffering person. Therapists’ negative feelings, such as frustration, boredom, fear, anger, and hate, are described as “forces that pull therapists from their professional ideal” (Wolf, Goldfried and Muran 2013, 4). The self-protective reaction of therapists has good reasons. A clinical observation, shared among psychotherapists to such an extent that it has become a part of psychiatric textbooks, warns that working with a depressed client can pull therapists themselves into a

kind of low mood and they have to be cautious not to fall too deeply into it (Rahn and Mahnkopf 2000).

Therapists, who are exposed to clients' powerful depressed emotional states, are generally not well prepared for this. They are often trained in therapeutic openness and an empathic stance and not in protecting themselves from vicarious experiencing. Self-doubts or warm feelings towards clients, who due to their depression are unable to respond, are examples of experiences that burden therapists and can gradually destroy their work enthusiasm and well-being in an imperceptible way. Therapists "look at their clock every 5 minutes hoping for the end of the hour while sitting with a self-absorbed client who barely recognizes their presence, they may become self-critical, feeling inadequate and regretting joining a profession that forces them to subordinate their own needs to those of another" (Wolf, Goldfried and Muran 2013, 5). A depressed client's helplessness and hopelessness is specifically recognized as a trigger for strong negative reactions in their therapist (Levenson 2013). The therapist can then be captured by their negative emotions and perceive themselves as helpless, which can subsequently create doubts in beginning therapists about their professional suitability, and cynicism and despair in experienced professionals about their effectiveness (Wolf, Goldfried and Muran 2013).

Working with depressed clients can not only erode a therapist's professional self-confidence but also endanger them personally. "Wounded healers", psychotherapists who have personal histories of psychiatric hospitalization, experienced among other reactions also varying degrees of identification with clients (Cain 2000). Research studies show that dispirited and depressed clients have a significant stressful impact on therapists (Deutsch 1984), negative experiences with difficult clients are a risk factor for professional distress and burnout syndrome (Jenaro, Flores and Arias 2007), and depressed clients were also rated as evoking the greatest degree of therapists' own depression (Brody and Farber 1996). Thus, therapists can be seen as risk workers, who are endangered by their own depression, which is one of the most common expressions of psychotherapists' professional crisis (Gilroy, Murra and Carroll 2002).

Numerous studies repeatedly show that depressed people evoke rejecting or even hostile reactions in others (e.g., Gotlib and Robinson 1982; Gurtman, Martin and Hintzman 1990; Marks and Hammen 1982; Paukert, Pettit and Amacker 2008; Strack and Coyne 1983; Winer et al. 1981; Gurtman 1986). Therapists, who are of course present in the therapy situation as human beings, cannot avoid experiencing these generally

human, self-protective automatic reactions when finding themselves personally endangered by being pulled down by the whirlpool of depression.

The above-mentioned research findings describe the depressed phenomena from the perspective of one-person psychology, exploring how the therapist is influenced by the depressed client. Therapists' reactions can be understood as natural human responses. However, when observed from the relational perspective, we can also see that by reacting in this way they participate in co-creating the depressed experiences by detaching themselves and so supporting the hopeless experience of the other being unreachable. In this way therapists are co-creating the experiential relational phenomena, they are depressing together with their clients in the here-and-now therapy situation.

The research findings mentioned here can be read also from the field theory perspective. Therapists not only contribute to the depressed field organisation by their natural human reactions. From the field theory perspective, their experiences can be seen not as reactions to the client, rather as functions of the depressed situation whirlpool. The situation is depressing both the client and the therapist, and their experiences reflect how they find themselves moved by the situation. At the same time, their experiences play a part in distorting the natural flow of the situation and so they help to fix the whirlpool of the depressed situation.

6. Interventions protect the therapist

Until now, therapist's feelings and body experiences were discussed. What are their behaviours? What do therapists do in a depressed situation? We have explored the polar nature in their experiences of being pulled down on one side and striving to protect themselves on the other side, but how does their behaviour reflect these experiences in being also polar.

● On one side, there is a *passivity resulting in aggressivity*. Therapists can become passive in the presence of the depressed client, overwhelmed by the feeling of helplessness. However, after a while it becomes unbearable for them. Therapists feel a self-protective need to differentiate themselves from the experience of their clients: *"I was saying to myself: My god, I must never become like this"*. The client's experience seems incomprehensible to them or they belittle it: *"It seems unreal to me that something like this [state of mind] can exist. It is a totally unbelievable thing for me"*.

Therapists then become impatient and frustrated. *"I am angry at him, feeling that I would like to kick him [to make him move]"*. They implicitly start to blame their clients for their own failures and they feel angry: *"I*

simply feel a kind of anger. I am really angry. [...] The immobility, the inertia [makes me angry]. [It is] as if you're trying to call into a black hole". Therapists' perception of their clients becomes narrowed, dehumanized, they start to see their clients just as carriers of symptoms, symptoms that their clients resist changing according to their therapists' expectations: *"Kind of feeling like [saying to the client]: 'If only you would want a bit, try a bit more, it would be possible!' So, this is what it evokes in me".*

Then, they can decide to stop the therapy, because they perceive it to be useless. They can feel a tendency to avoid further contact with the client, and they consider sending the client to another, more competent expert. They feel the responsibility for further change in the client, but they do not see a real possibility for this change to happen. They might blame the client for not being motivated to make even the slightest changes themselves. Or, they might blame themselves for not being competent enough to help such a difficult client. In both cases, the unbearable feeling of helplessness is managed by a behaviour that is aggressive either towards the client, or towards the therapist. Such a behaviour may serve well as a protection for the therapist, but it only confirms the relational vicious circle experience for the client.

Polar to the passivity resulting in aggressivity is therapists' tough activity resulting in resignation. To protect themselves, therapists do not expose themselves personally, they take a safer, experientially-more-detached expert position. Instead of being with the suffering person, they focus on the symptoms of their client's depression. This provides them with a feeling of distance, which enables them to escape from being experientially pulled down by the whirlpool of the depressed situation. They become active, take a more directive therapeutic approach, give practical advice to their clients, and try to help them solve their problems: *"It tempts me to look for a solution".* Therapists strive for an effective treatment of depressed symptoms and they take responsibility for the change in the client.

Although therapists aim to change the symptoms of a client's depression to help the client, in fact they are helping themselves. Active intervening helps them to escape from being drawn into the feelings of helplessness: *"I get activated by that person. I start to be very active all at once, I start to invent, I start to have a lot of suggestions, and I start to take care of him. [...] I know it is almost a kind of trap that I can get caught up in. That it is easier for me than to stay with him [in the depression]".*

Therapists are trying to supply their clients with optimism, to change their clients' attitude towards themselves and the surrounding world, to divert them from their current depressed experience and focus on pleasant and positive aspects of life, and to value their clients' qualities and potential. Later they realize these interventions served to help themselves to handle their own experience: *"I feel the heaviness [...] and I am trying to show [...] that actually just the fact that he came here is meaningful. That he is doing at least something. And many times, I have realized that I am doing this more for myself in that moment"*.

This way therapists also further fix the vicious circle of depression, and support the whirlpool of the depressed situation. They become polarized against their clients' depressed experience: *"A kind of mobilizing potential [...] starts coursing through me kind of automatically. The gloomier the person is, the more fiercely I mobilize myself"*. This works also vice versa. The more mobilized the therapist becomes, the gloomier the client is.

This is why such interventions do not bring a therapeutic effect to the session. Therapists' efforts to change the symptoms of their client's depression appear fruitless for the moment. Encouragement, activity, and an optimistic approach do not lead to a change, and therapists become disappointed with the results of their efforts. Clients are not changing according to their expectations. They stay depressed, immersed in their feelings of emptiness, resignation, and hopelessness. Therapists reflect their work as *"pushing somewhere where the path is closed"*. The therapy situation gets stuck and they see the client become *"fossilized... in the same cyclical topics and the same repeating sentences: that nothing has any meaning anyway and that she will never get rid of it [depression] and that the world is so joyless..."*. Therapists finish in resignation, feeling hopeless, and finding themselves being pulled down by the whirlpool of a depressed situation again, only this time they are more tired after their fruitless effort to change the symptoms of depression.

The general relational patterns described above are experienced by therapists in contact with a depressed client. From the field theory perspective, therapists find themselves being defined by the depressed situation dynamics as they become a function of it. Such a perspective brings a very important new way of understanding therapists' experiences. In a way, such patterns leading to a therapist's helplessness, hopelessness and exhaustion present a sign that the therapist is really, genuinely present there as a person. It is a sign that the desperate client's longing for a bond succeeded in getting through the therapist's armour of professional skills and self-protective expert mask, in appealing to the living heart of the other. If we understand the depressed client's suffering as an expression of

a longing for the other, we can also see the helplessness of the therapist as an expression that this longing was heard by the other. As was noticed earlier here, help in psychotherapy works in a paradoxical way from this perspective. Therapists' active interventions work for them as a way of escaping their helplessness, whilst the therapist's helplessness works for the client as a way of genuinely being with the depressed client.

7. Counter-movement of mind

For a healthy situation, the natural flow from the here-and-now to the next is essential. In depression, this natural flow of the situation gets blocked and distorted. The situation gets stuck. However, the flow with all its power is in fact still present there, but it moves in a narrowing vicious circle, digging a deeper and deeper hole, a depression.

What blocks and distorts the flow of the situation? Searching for the answer, the strong longing for relating to the other that brings the experience of being alive can give us a clue. There is a dread present in the situation that such an experience will never happen. It is an existential, deeply embodied horror, a fear of being totally alone in the world, which is dead, intact, empty. It is the nightmare of a new-born child, who finds itself being brought into a cold, dead abyss, and is left abandoned there.

In a healthy situation, such an abyss is also present as a polar potentiality, as the other side of the potentiality for meeting the other. Such a possibility of a total abandonment is present in the situation, but usually it is mercifully covered by a hopeful stance, so participants in the situation experience it just in the occasional slight grips of an existential anxiety.

However, in depression, the hope is not present, and so it does not protect the participants in the situation from experiencing the existential abyss. Such an experience then appears too endangering, confronting the involved people with a real possibility of the very bases of relational human experience being taken away. It is so deeply existentially endangering and it evokes such an extreme horror, that facing it directly seems impossible. So, the flow of the situation turns away from facing this horror. The situation organizes itself in a kind of creative adjustment that allows an avoidance of the direct experiencing of the abyss. The flow of the situation gets distorted into the whirlpool of depression as it was described above.

However, as a result, the effort to avoid the horror of an abandonment by turning away from the abyss paradoxically leads to the abandonment brought about by the whirlpool of depression. This hopeless vicious circle

of the situation is expressed by the client in the depressed symptoms and it is also experienced by the therapist.

For therapists, the natural impulse is to help suffering people, to bring at least some relief to them. In both the therapists' behavioural reactions described above, the passivity which leads to aggressiveness, and the activity which leads to resignation, therapists feel responsible for the change, for a result in the therapy, for helping the suffering person in front of them. It is this felt responsibility that fixes them in the depressed vicious circle pattern. Therapists either put this responsibility on themselves, and then they become frustrated by themselves, or they put the responsibility on their clients, and then they become frustrated by them. Either way, the frustration is managed by an aggressive behaviour, which leads to detachment from the client.

It is exactly at this point that the concept of situation offers hope. When we consider the situation as having its own dynamics, it frees us from feeling the responsibility for the result, and at the same time allows us to stay in the process of the situation and take part in its flow. The natural flow of the situation is distorted, however it is still present as a potentiality of the situation. Moreover, the suffering of the relationship offers us hints on how to release this potentiality. Adopting such a perspective takes the responsibility for the result from our shoulders. Establishing a paradoxical mind set of feeling not responsible for helping the other while responding to the existential relational longing of the other, presents the first step out of the whirlpool of the depressed situation. Therapists need to give up their expectations while maintaining hope. They need to surrender to the between (Yontef 1993), and follow the hidden "wisdom" of the situation.

Such an approach must not be mistaken for passivity. It is an active state of being genuinely and responsively present with no expectations from the other or from oneself. Practising such dialogical meeting without aiming (Yontef 1993) is especially demanding in a depressed situation, because it requires an embodied rebellion against the natural survival impulses. The impulses that force both the client and the therapist to use every possible way of avoiding the horror of being abandoned in the abyss.

As mentioned earlier, the whirlpool of depression gets paradoxically strengthened by the survival impulses. To change this, a paradoxical approach is needed too. The seemingly unnatural movement towards and into the horror is a way of redirecting the power of the situation from deepening the depression to gradually dissolving the obstacle that is blocking the natural flow of the situation. In order to survive, it is

necessary to act against survival impulses. It is extremely demanding to make this counter-movement, to face the deeply embodied fear and to go into it. The client is too exhausted from the long suffering to make such a movement, therapists need to do it first. They need to face the dread in order to encourage clients, to offer them the experience that it is possible to survive such a dangerous, unnatural movement against survival impulses. So, therapists need to start in their own mind, making a mind movement, which contradicts where the natural instincts would lead them. By making such a counter-movement of their mind, they are changing the way they are with the client.

8. Giving up and keeping hope

The most important mind move seems to separate hope from expectation. Such a move can happen at a certain point during the meeting, when the therapist reaches a turning point where they admit that their efforts to relieve the client from symptoms of depression are not successful. They find themselves exhausted and frustrated from trying to change the symptoms, an impossibility at that moment.

It is exactly at this point that the situation itself generously offers them a clue for the appropriate approach. They need to give up their expectations of the client that he can actively change something to become less depressed, and of themselves that they can help the client to become less depressed. The dynamics of the situation itself, experienced by themselves as exhaustion, frustration, helplessness, hopelessness, nicely leads them to stop struggling and to become reconciled to the actual limited possibilities for the client and for the whole therapeutic situation. They are invited by the situation to accept the given reality of their client's actual state and to start to change their therapeutic approach: *"I realize [...] that my hastiness or rapidity or heaviness is pushing me to be fast, demanding... So I [change it and] I just stay there [...] I am more silent again [...] adjusting myself to his speed"*.

Therapists give up their expectations, which enables them to leave the role of an expert responsible for making the change, and opens their capacity to really experience the presence of the other in front of them: *"I stop prompting him to move, and I join him instead"*. And, it also enables them to be really present there for the other as a human being, naked without the helping expert role, and unprotected without the therapeutic skills: *"I can sit with her, but I cannot help her"*. Instead of focusing on symptoms, therapists can turn to the relationship: *"I am joining her"*.

Nothing gets better really, we will not come to any solution, will not come to anything [new], but a kind of contact can happen. I am with her”.

Therapists keep the inner tension between a natural tendency to protect themselves on one side and their professional responsibility on the other. They are no longer taking on the responsibility for the result of the therapy session, nor are they placing the responsibility on the client. They can find themselves led by the flow of the situation itself, trusting in the current of life (Yontef 1993), which brings them relief, and makes their work personally meaningful again for them: *“It was a relief... It really was a relief, when I had the feeling that it [changing depressed symptoms] is not a kind of duty. [...] That [just] our meeting by itself [...] has some positive effect for her [...] So this really helped me”*. This way therapists are experientially escaping from the whirlpool of depression. They can start to perceive the situation as meaningful again. Finding a meaning enables them to escape from the paralyzing influence of hopelessness. They experience a freedom, which enables them to stand the depressed situation without expectations, and so to be available for the other, opening a chance for meeting the client.

Precious, as much desired moments can then arrive, when the client too can experience the true presence of the other. In these moments, the potentiality of the situation for the natural flow is released, bringing a massive relief. This relief is felt as an embodied experience, the therapist's body then reflects how the flow of the situation is released, and this in turn supports them and helps them to resist being pulled down by the depressed whirlpool: *“Well, I have a feeling that it... that it helps me, when exactly these moments of some deeper contact happen. That I start to perceive it a bit meaningfully and somehow in this way I can like the person despite all that. It helps me that there is not only the darkness, but actually also something alive. Something really alive! [It helps me] that there is not only the ‘death’, [...] [but also] life is there... When I got closer to her, I did not feel only her depression, but also her as a being”*.

However, the situation is far from being easy. In fact, there might be very little change observable. Therapists experience ambivalence. They feel relief when abandoning the unproductive effort, but they remain in the unpleasant experience with the client at the same time: *“It was like grounding firmly. You sit down, stop floundering in a kind of activity, you just simply sit down. On the one hand it is a relief from activity, but on the other, you are still sitting in something nasty”*. Until now the difference has happened mainly in the therapist's mind. Although invisible, this changed mind-set establishes an essential ground for the change in the situation itself. Therapists are present in the depressed situation differently

because they attune to the intentionality of the situation, and so the way they are present is transformed. Therapists do not change the situation, but by supporting themselves they become free in the situation, they stop limiting themselves by fearing the power of being pulled down. Their freed position enables them to notice the underlying hidden potentiality in the natural flow of the situation, and to allow themselves to be changed by it. In this way their changed way of being present builds a ground for the restoration of the flow of the situation.

9. Not frightening hope away with optimism

After therapists have set the ground for the change, as described above, they can support the re-establishment of the natural flow of the situation. They do not push the river, they are not striving to change the depression. Instead, they invite the change, they allure it. How can it be done?

There is an instinctive reaction to horror: turn away from it and run as fast as possible. As useful as it can be in many life situations, when facing the horror of the depressed abyss therapists need to do the exact opposite. They need to make a kind of counter-movement, face the horror and move slowly towards it. This counter-movement can be divided into two parts. The first part happens in the therapist's own mind as described above. The second, behavioural part, is based on restraining their own tendencies to act fast.

In the first part of the mind counter-movement, therapists face the horror of the depressed situation as they experience it themselves in feeling helplessness, hopelessness and exhaustion. By facing the abyss therapists set an essential ground for change because they start to erode the fixed pattern by which the situation is organized. They do not follow two common polar basic reactions to a depressed person, depressed mood induction and rejection (Coyne 1976b), reactions which enhance the whirlpool of depression in the relationships outside the therapy situation.

Therapists do not react in any of these usual ways. Instead, they do what seems to be the most unnatural and dangerous in the depressed situation. They stay open and perceptive. Therapists do not follow the first impulse, which is evoked by the fear of the abyss and a desire to change the situation: "*It tempts me to look for a solution*". It is an impulse which would contribute to fixing the field organisation. Instead, they do not react but wait for the second impulse to appear in them.

As opposed to the first impulse, the second impulse can provide an experientially perceived information about the client's unmet relational need (Evans and Gilbert 2005). Moreover, it offers an invitation for

therapists to take part in meeting such a need. So, what is needed from therapists is to let the first wave of their own feelings go, to bear the helplessness, and to wait for what appears next in their process of experiencing. The second impulse, which appears then, is extremely precious, because it shows the way out of the whirlpool of depression, the way which allows the natural flow of the situation to be restored. This way is not invented by the therapist, nor by the client, it is offered by the situation itself.

Therapists wait for the second wave of experience, which is based on acceptance of the situation. *“Nothing gets better really, we will not come to any solution, will not come to anything [new], but a kind of contact can happen. I am with her”*. We can understand this process from the perspective of the paradoxical theory of change (Beisser 1970). When therapists strive to change the depression they paradoxically fix the depressed organisation of the field. Only when they accept the situation as it is can it start to change.

10. Not standing in the way of change

What helps us to cope with our own experiences when working with depressed clients? The most important thing is simply to stand it. *“It is hard to bear it at that moment. Bear it when you know, that in fact... that I cannot do anything with it, I cannot work with him on anything concrete. It is just about being there with him. Simply to stand being there with him somehow”*. This requires a special competence to deal with the unknown, which consists primarily of the courage to sit with uncertainty (Melnick and Nevis 2018). Therapists use different strategies for being able to cope themselves with their first instinctive impulse without acting it out. In our qualitative study (Ebertová 2016) several such coping strategies were identified, such as conceptualizing the situation within a bigger context, focusing on one's own needs, physical grounding, slowing down, or realizing the limits of one's own responsibility. Here are some examples of how such strategies are used:

The way the depressed situation gets organized affects the perception both of the client and of the therapist. Difficulties can assume monstrous dimensions, it may seem the depression will last forever, but when therapists also allow themselves to perceive a broader context, another picture starts to appear. The deepest part of a depressed episode can take for example two months. Obviously, it is a long time for the client, but for the therapist it can mean about eight sessions. This is bearable, it is not infinite. When therapists put the situation into a broader time and space

context they can realize the obvious fact, which was however hidden in the background by the whirlpool of depression, that the therapeutic session will not last forever, that the demanding experience will finish in a certain time. They realize that they actually have the capacity to stand being really present with the client here and now for a limited time, and that they will step out of the depressed field organisation after the session. *"I have the power to finish the session to be here and now for the person. Because [I know that] it will finish for me then [when the therapy session ends]"*. Therapists realize the broader reality context: this is a therapeutic room where we meet as therapist and client for the limited time of a therapeutic session. This way they no longer share the clients' distorted perception of the situation when time and space vanish (Francesetti and Roubal 2013) in the whirlpool of depression, and they recall the sense of a time flow from the background of the situation to the foreground.

Therapists can anchor themselves in a "third party" (Francesetti, Gecele and Roubal 2013) and rely on their theoretical knowledge of depression. They can also recall what had helped them in therapy with other depressed clients. They realize they have handled a similar situation before and have a capacity to stand it now too. It is useful for therapists to conceptualize the situation. They create a meaningful concept that helps them understand the current situation. They realize, for example, that the client had started to take antidepressants and that the therapist's task is, for the moment, limited to complementing this treatment and supporting the client until the effect of antidepressants appears. Later the therapy work can have more ambitious goals, but for the moment such goals would just increase the frustration and hopelessness.

Already by using the above-mentioned coping strategies in their minds, therapists open a space for a change. They free themselves from being imprisoned in the usual fixed ways of reacting to the depressed person. They take a courageous step and face the horror of the depressed abyss. By accepting their helplessness while maintaining contact with the depressed person, they implicitly hope that it is meaningful to stay, even if the meaning is not seen through the mist of hopelessness. *"Even if I do not see the hope, I somehow hope to see it again"*. Their experience of freedom, courage and hope becomes now part of the situation, and so the situation itself becomes different.

It is not so important what we do, but how we are with the client. Or, let us say, whatever we do in our interventions it is important for us to calm down, to be able stay quiet enough to listen to the tacit call of the potential, natural, fluent flow of the situation longing to be released from the prison of the vicious circle of depression. By changing our way of

being with the client the situation itself follows the transformation process, the fixed dynamics of the field processes are re-directed, and a chance appears for the natural flow of the situation to be restored.

Then, our main task is not to stand in the way of this newly developing movement because it finds its own way in the unique conditions of the here-and-now situation. A way that we cannot plan or arrange, we cannot even foresee. The change might happen, and we welcome it, whatever shape it takes. We as therapists do not make the change, we just open a door for it. Maybe the flow of the situation affects it and the change starts to happen. If it does the dynamics of the situation are transformed and the client and the therapist as individuals, being a function of the field, are transformed too.

11. From escaping to exploring

By consoling clients, by trying to save them from the depression, we may find ourselves just trying to protect ourselves from being pulled down by the whirlpool of depression, and so we may be supporting the client's experience of not being seen and met. Restraining such tendencies to fast actions represents the behavioural part of the therapist's counter-movement. Truly listening to the suffering of the other means to stay open and receptive in the situation, where our instincts would make us run away. Trying to help the client can serve as a way of escaping from really meeting the client. In order to help the client we need to stop escaping from encountering the suffering. As Carl Rogers puts it: "You cannot help anyone without risking yourself" (as cited in Anderson 1997).

Depression is often perceived as a swamp both by clients and therapists. They both get stuck in the swamp and they perceive it as dangerous. Instinctively, people in a swamp start to panic and try to move fast to jump out of it. However, the faster they move, the more they get stuck, and the more urgently they jump, the deeper they sink into the swamp. They need to stay calm and move slowly. As opposed to vertical jumping, their movements need to be horizontal, in order to explore the terrain rather than escape from it. There might be some pieces of firmer ground somewhere around that cannot be seen from above, they need to be touched and tested in the swamp. Metaphorically, this is the nature of therapists' actions in depressed situations.

Therapists do not stay passive, if they did their own heaviness would sink them into the depressed swamp. Nor do they try to jump out of the depressed situation, which means that they do not set high expectations for themselves or for the client, they do not push for improvements. Jumping

would just pull them deeper into the swamp, as they would end up frustrated when their expectations were not fulfilled. Instead, they slowly explore the situation in a broader context, they make small horizontal movements and they patiently test what can be used as a supportive ground in the swamp.

For example, therapists can explore a broader time context for the client's state. By simply naming the time frame - when the client started to feel depressed - can bring the sense of a time flow, which is missing in the depressed client's perception. If clients have experienced the depressed state already earlier in their life, just explicitly naming how long it lasted then can introduce an implicit hope that this depressed period will also finish. A firm piece of ground appears in the timeless swamp.

Monitoring the severity of the depressed state can be also helpful in this broader context. When the depression is conceptualized by therapists as a wave, where the mood gets depressed in the beginning and then slowly improves, clients can point to where they actually feel their position on such a wave. Merely accepting the current state is intrinsically potent (Melnick and Nevis 2018). Only by phenomenologically describing their current state within this dynamic concept of a mood wave can the client start to feel the sense of flowing time again. This way, by moving from the background of the situation to the foreground, an implicit hope is invited by the therapist without persuading or comforting the client. The situation can start to flow, the whirlpool may be transformed into a wave and the depression into a natural healing process of mourning.

12. Welcoming liveliness within the depressed situation

As a figure emerges from the situational background, the background drops away and out of awareness (Perls, Hefferline and Goodman 1951). In the field organized in a depressed way, we experience that the aspects of the situation that pull depressed people down and deaden them come to the foreground, while in contrast the enlivening aspects of the situation withdraw to the background. This could be illustrated by a common experience of depressed people, who perceive the world as uniformly grey. Only when the field is no longer organized by depression can people start to see colours around them, the colourful vital aspects can become foreground again.

Therapists find themselves falling experientially down together with their clients into emptiness, greyness, deadness. However, when they realize that this deadness is just one side of the current situation, the aspect which has become a figure, it helps them to focus on those aspects that

were in the background until now. Therapists do not strive to change the situation by bringing aliveness from outside, but it is important for them to focus on the liveliness that is already present in the therapy situation here and now, although in the background. They can find aliveness in the situation itself, in themselves, *"I realize I have sometimes a need [to] rebel in a way. [...] I have a need to do kind of a fast movement or something [like that]. [To feel] that I am alive!"*, or in their clients and in the therapeutic relationship, *"When I got closer to her, I did not feel only her depression, but also her as a being"*.

By giving up the effort to make an immediate change, therapists move their focus from lifeless symptoms to a vivid person whom they meet in the moment. Bringing the relationship into the foreground represents a key moment, which in the whirlpool of depression creates a firm base on which the therapist and the client can stand. The process of therapy seems to stagnate, the symptoms of depression stay the same, but the client and the therapist are both in it together now.

In fact, the process of therapy does not stagnate; it just does not progress towards making depressed symptoms better. Instead, it evolves in another way, deepening the therapeutic relationship and so building the necessary relational bases for a change. So, if it happens in therapy that the client's depression is not changing, a therapist can understand it as a signal that the relational basis of the situation needs to be strengthened, that the need for a relationship is becoming a figure. Therapists just need to listen to this need, to put aside their own expectations and to trust that the flow of the situation can be restored by strengthening the relationship. The relationship, which presents a potentially vivid aspect of the situation.

For example, therapists sometimes can share their experience with the client: *"I imagine that maybe through the helplessness and tiredness which I am experiencing now, I can be in touch with what you have to live with all the time. It helps me understand how hard it must be for you"*. Therapists use their experience to move towards the client, to reach their hand across the depressed abyss. The client might then feel seen and understood. It can be just for a very short moment, but even this can bring the hope that reaching the other does not have to be totally impossible.

Focusing on liveliness already present in the situation brings hope to therapists and helps them cope with their own experience in the presence of a depressed client. However, this hope is of a paradoxical nature. Therapists can experience the hope that a change will come just when they stop striving for it, when they reconcile themselves to the current hopelessness. This stance reminds us of the paradoxical theory of change (Beisser 1970) applied to a specific situation with a depressed client.

Therapists can support themselves by referring to a mantra from T.S. Eliot (1971, 28): “Be still [my soul], and wait without hope. For hope would be hope for the wrong thing”.

By using self-supporting strategies for themselves, therapists also bring these strategies into the shared field with the client. It is important to realize that the shared field is not only organised in a depressed way, although that is in the foreground. By relying on their self-support, therapists are already influencing the experiential field shared by the therapist and the client, they are supporting the figure-ground change. Self-support can then appear as a possibility in the shared space of the situation, it can gradually start to move from the background of the situation to the foreground as one of the characteristics of common field dynamics. Therefore it would influence the client too. The potentiality of self-support can then open itself also for the client in the situation.

13. Transforming abyss into fertile void

At this point, we can come back to the beginning of this chapter, to the reports from therapists who so honestly shared what they experienced with a depressed client. In the very special dynamics of the depressed situation, where time infinitely lengthens, where space between people seems unbridgeable and the other unreachable, where every movement, even a mind movement, requires a tremendous effort, like walking deeply immersed in mud, therapists find themselves hopeless, helpless, lonely, exhausted. When experiencing all this therapists risk themselves. They face the archaic, existential fear of a total abandonment. The total abandonment of a new born child, who does not have the concept of oneself as a person available as a self-support, and who is so totally dependent on the relationship with others. And, this is actually what therapists experienced. They lost their own self-concept. They stopped perceiving themselves as a person who has the task and capacity to help. *“When I get closer to that client in my emotions, there is a kind of limit, when I say to myself: ‘It is so heavy!’ [And to the client:] ‘Man, you should go to see a psychologist’. Then I realize he is actually there! [...] I forget I am the psychologist here, because I perceive how very heavy it is for me when he describes it to me”.*

The very basic nature of the therapist’s presence becomes transformed in the field structured by depression. They are not in contact with their liveliness, with their potential, they delegate their competence to someone else (some psychologist), they lack creativity. The dynamics of the depressed situation transforms therapists, as well as clients. They both are

functions of the depressed field here and now. We can imagine this depressed field as a mycelium, invisible and ever-present in the ground, which shows up as an observable form of mushrooms: the client's symptoms of a clinical depression, and the therapist's experience of hopelessness, helplessness and loneliness.

It is just all right. There is no need to blame anyone for that, neither the client, nor the therapist, nor some outer persecutor or bad conditions, because it seems that such processes are inevitable when we decide to work with depressed clients. We expose ourselves to what is understood as "emotional contagiousness", which can be explained by instant automatic imitation and synchronization of behavioural expressions of emotions (Hatfield, Cacioppo and Rapson 1993) that happen naturally and often without consciousness. In their meta-analysis Joiner and Katz (1999) substantiate that depression is "contagious", not only emotionally but rather as a complex of all its symptoms such as helplessness, tiredness, anhedony etc. Levenson (2013) described these "automatic" and "universal" emotional responses, manifested also on a bodily level, stating that the therapist to a large extent does not have a choice in whether to contain or express them. Le Doux (1996), in his neuroscience findings, distinguishes this automatic emotional response transmitted through the amygdala from the emotions produced by the thalamus-neocortex pathway, which is slower, but enables more conscious processing.

Neuroscience research dealing with the interconnectedness of mind, brain, and relationships explains this phenomenon further. Premotor cortical neurons called mirror neurons (Gallese and Goldman 1998) display the same pattern of activity, both when the subject accomplishes certain goal-directed activity and when one observes the other performing the same action. This neuronal activity is "primarily of a practical nature... for it involves the direct pairing or matching of the bodies of self and other. There seems to be an immediate pairing" (Thompson 2001, 9). Firing among the mirror neurons in the frontal and parietal regions of the cortex and related areas "creates a neural image of the mental state of another person [...] The image of the other's intentional state is then used to initiate behavioural imitation and internal simulation" (Siegel 2012, 176).

We can say that the therapist's brain pairs itself immediately with the brain of the depressed client, before the therapist can even notice or consciously influence it. This therapist's "internal simulation" of the client's mental state can be understood as an observable phenomenon that is a function of the depressed situation dynamics. It seems that, due to the automatic nature of such a response, therapists cannot avoid it even if they

have already experienced and reflected on it many times in their previous work. The neurocognitive mirroring networks in the brains of both client and therapist together create something new, something that exceeds the sum of the presence of two independent brains. The whole is more than the sum of its parts. What is more here, is the in-between “mycelium” of the situation, a meta-phenomenon, which has its own dynamics and which defines the parties involved through the neurocognitive processes.

Being immersed in the depressed situation, therapists themselves experience depressed symptoms as hopelessness, helplessness, loneliness, exhaustion etc. The client and the therapist are thus “depressing together” in the here and now in the therapy situation. This presents a precious “gateway of empathy” (Siegel 2012, 165) and opens the “intersubjectivity of consciousness” (Thompson 2001, 15). As neuroscience shows, “sharing of basic appraisal and arousal processes establishes the fundamental way in which one person becomes connected to another within emotional relationships” (Siegel 2012, 169). The depressed situation is therefore not only pulling the therapist down, it also offers a guide to the recovery of the flow of the situation, recovery which can start from letting the potentially vivid relational aspects of the situation become figural. Therapists’ own situationally depressed experiences are bridging the interpersonal “abyss” (Francesetti and Roubal 2013) that appears in the depressed situation. Such bridging is already healing, because it facilitates the development of a parallel, pre-frontally mediated process in the depressed person, as the “intimate, reciprocal human communication may directly activate the neural circuitry responsible for giving meaning, responding flexibly, and shaping the subjective experience of an emotionally vibrant life” (Siegel 2012, 169).

Indeed, higher nonverbal synchrony between client and therapist is proven to be associated with the client’s self-reported quality of the therapeutic relationship, their experienced self-efficacy and also with higher symptom reduction (Ramseyer and Tschacher 2011). On the basis of current neuroscience findings, Greenberg (2006) stresses the right hemispheric and nonverbal influence of a therapeutic relationship, which most effectively approaches the depressed client’s affective self-regulation processed largely without conscious awareness.

The process of change in the psychotherapy of depression can be then seen as a transformation of the interpersonal abyss into a shared experience of emptiness, which then can enable meeting the other and bridging the abyss. “To perceive the other, the open intersubjectivity essential to perceptual experience must be already there” (Thompson 2001, 15). The transformation of the depressed interpersonal abyss into the

open intersubjectivity happens through the presence of therapists, through the way they risk themselves in the whirlpool of the depressed situation by facing the archaic fear of the depressed abyss unprotected by therapeutic interventions.

14. Clinical case vignette¹

A 74-year old lady experiences *"hopeless emptiness"* in her life. She wakes up at half past three in the morning and then stays in bed until eleven, unable to mobilize herself even to brush her teeth. Feeling physically too weak to go to the bathroom, she lies turned to a wall, her head covered by a blanket, feeling how *"painfully alone"* she is.

What do I experience with her in the psychotherapy session? Basically, a kind of general heaviness. And something like: *"Ok, another one like this... Do I really have to listen to this?"*. And then: *"Hey, wake up, you are here to help her, do something!"*. Detachment and aggressivity followed by forceful self-activation. Alright, I notice my experience, the first wave of it, and I wait for the next wave. I have no idea what it might be.

This is what comes: *"Well, it's a bit strange. This lady is quite old for a first contact with psychotherapy. What brought her here? It could be quite special to work with an old lady like this. What hopes for the future can she have? And, what can I know about it, when she is almost 30 years older than I am!"* Curiosity, challenge. Sensing that there is something special in her, feeling slightly tempted to start an adventure together. I feel intrigued to challenge her own resources.

"Hmm, yes. I can hear how hard it must be for you now". Should I dare to follow my second wave of experience, and be curious about her unique experience? *"And, I wonder what is so painful in it for you?"* Saying this, I move into the depressed swamp. I make a counter-movement against the instinctive first reaction. I do not detach myself from the client, nor do I try to console her. If I were to do this I would send a signal to the client that I am not taking her suffering seriously.

When I ask her, *"What is so painful for you in it?"*, she looks at me as though reassuring herself that I mean it seriously. Then she replies: *"I*

¹ I am presenting here my reflection of the therapy process. At the time of my meeting with the client, my approach was informed mainly by my experience-based intuition and driven by pre-reflexive sensing the aesthetics of our contact in the here-and-now situation. Detailed awareness came to me only after the actual sessions, when I could conceptualize what happened in the flow of our meeting together.

reproach myself for being inefficient. I accuse myself: you are lazy as a pig! Get up and do something! Pull yourself together!" Her face looks tough. I can feel, using my aesthetic sensing, how the atmosphere gets thick, how the flow of the situation gets stuck. Her face presents the embodied expression of the obstacle, like a stone which blocks the flow of the situation. *"How does it feel, when you say this to me?"* By referring to the fact, that she is saying it to me here and now, I am making a slow movement towards her. *"Well,"* she says, *"I feel like a good-for-nothing. Always, in my whole life, I have been working hard. No vacations, work all the time. It was me. Now, I am good-for-nothing..."*

Again, the stone blocks the flow of the situation. I can sense the thick and steady atmosphere filled with hopelessness. However, at the time when I hear the words *"no vacations"*, I could also sense a waft of change in my experiencing, slight curiosity like *"really no vacations for all these years?"* I sense it as a sign of a well-hidden possibility. Is this the direction in which the flow could go? A tiny indication of tending? I can recognize this secret, precious moment through the slight change in my experience. In the generally deadly atmosphere, I become more alive hearing the words *"no vacations"*, and I let myself be led by this signal.

I ask her about work. What was she always so busy with? *"I always had a lot of energy. Now, I am so tired..."* Again, I need not react by consoling or detracting, but rather take her suffering seriously: *"Hmm... and, how do you feel the tiredness?"* *"I am so tired all the time. The body has no power, I cannot move. It takes hours, until I persuade myself to get up from the bed. I am good-for-nothing."* I can again feel the heaviness, hopelessness, there is no flow, her face like a stone in the deadly atmosphere.

Yet, when hearing the word *"body"* I sense the waft of aliveness again. In my mind, a connection between the two mentioned wafts, signals of hope, appears. *"Vacations"* and *"body"*. It is like jumping from one firm point to another in a swamp. I suggest, *"Maybe your body takes vacations now...?"* She raises her eyes, surprised, and for a short moment it seems she has registered me as a lively person there.

We spent the rest of the session talking about how much she has been working in her life and how she in fact longed for a chance to get some rest. In the next session, she refers to how she still lies in bed all morning not able to stand up. But there is a strange difference, she says. The waft of a hope in my experience with her is stronger, I can sense it clearly now. *"What difference?"* *"Well,"* she says, *"when I was lying there for the whole morning turned to the wall with my head covered by a blanket, I tried saying to myself: I am taking vacations for all the years of work"*

now.” “*And, how was it?*” “*Well, it was the same as usual... but maybe, I will try it again, it’s such a strange idea to me...*”

Nothing has changed really, she stays depressed and exhausted, not even able to get up from her bed. However, her attitude to herself started to be transformed. There is quite a radical change from “*You are lazy as a pig!*” to “*I am taking vacations for all the years of work now*”. She tried to stop blaming herself, she tried to divert the fixed dynamics of the vicious circle, which made her even more tired. Instead, she started to learn to accept her state and legitimize it, she started to learn to feel compassion towards herself.

Although the fixed depressed pattern of the vicious circle is still strongly prevalent, it is noticeable now that the new “strange” idea is attracting her, and a hope for vitality can be sensed in it. What I needed to do to invite change was to express my openness, interest and support to the client, instead of following the instinctive impulses to save the client, or to protect myself. I had to overhear the silent little voice of hope in the middle of the whirlpool of depression, and then not to frighten the hope away with my optimism.

There is yet another thing that I did to invite change. I prepared a home for it, where it could settle. A home, which is presented by a new image, a new conceptualisation of the depressed experience. Instead “*I am good for nothing*”, there is now “*I am taking my vacations now*”. This new conceptualization offers a path for the flow that is no longer blocked by the self-criticism that turns impulses inwards. Instead of a depressed hole, a trap, there is another image appearing: a vacation after a life full of hard work. An image with its inner dynamics, a home into which a change is invited.

15. Conclusion: the situation paradigm

In this chapter, I have offered a perspective of the situation process that we can adopt to understand the experience of a therapist when meeting a depressed client from a field theory perspective. The relationship is considered to be the formative power of the situation, a central process that defines the situation participants’ on-going and ever-changing way of participating in the situation. From the field perspective, the relationship is not considered as being co-created by involved individuals. Instead, the involved individuals are seen as functions of the situation, as processes that are formed by the flow of the situation.

Evans (2007) distinguishes three paradigms or world views in the history of Western philosophy, and he connects them to psychotherapy:

Classical, Modern, and Postmodern. “God is, therefore I am”, could paraphrase the Classical paradigm, including the Platonic notion of reality based on transcending forms in the Jewish and Christian traditions. Descartes’ “I think, therefore I am” could characterize the Modern paradigm from the Age of Enlightenment, and presented a paradigm shift from a theocentric to a ratio-centric way of thinking. The twenty-first century Postmodernism challenges the foundations of what we know and how we know what we think we know (Evans 2007), and “demystifies the great narrative of modernism” (Gergen 1992, 28). The Postmodern paradigm stresses the co-creation or co-construction of all relationships, and so the therapeutic relationship is seen as an interactional event in which both parties influence each other: “You are, therefore I am” (Evans 2007).

We can use the concept of paradigms to distinguish different kinds of conceptualization of the process of change in psychotherapy: How the change happens and who is making it. In the “modern” paradigm, currently prevailing in the Western health system and so in psychotherapy, which is a part of this system, the change is perceived as made by an expert, who is helping their clients by repairing their disorders. Earlier, in the “classical” paradigm, psychotherapy was not yet established, however similar change processes were happening in other, mainly spiritual contexts. The change was perceived as made by an external power, on which the helping person was competent to call for help. In the currently developing “postmodern” paradigm, which is increasingly influential in psychotherapy, the change is perceived as being co-created by the therapist and the client together.

Maybe we can sense the appearance of a new paradigm in psychotherapy following those mentioned above. The change is not perceived as “made” by someone, rather it is seen as a process with its own dynamics that transcends the involved individuals. The change is happening and the process is “using” the involved people for the change to happen. From this point of view, the “postmodern” concept of a dialogical co-creation of a change seems still too anthropocentric. It may also be seen as uncritically omnipotent: you and I together are making the change. Well, how can we be so sure? The “situation” paradigm, as a provisional working name, overcomes this with a humble recognition that the change can happen in a way that is not intended, understood, or even noticed by the therapist and the client.

“You and I are being formed by our meeting”. Maybe like this? It can remind us of the “classical” paradigm: “God is, therefore I am”. Indeed, they are both built on the experience that there is some transcendent power

influencing or enabling the change. However, in the “situation” concept, the transcendent power is free of religious introjects determining how this power should be perceived. It is based purely on the experience of an embodied presence in the flow of the situation. “We perceive no *Thou*, but none the less we feel we are addressed and we answer... with our being” (Buber 1937, 6). The current growing interest in altered states of consciousness connected with the use of psychedelics in psychotherapy can be seen as a sign of the coming paradigm shift. The perspective of a situation that transcends the individual is natural, even essential for working with such states.

The recently growing, research-based emphasis on the role of the psychotherapy relationship in the change process can support psychotherapists in exploring how to be with the client in an effective way. Psychotherapy and neuroscience research can help practitioners to reflect and cultivate this competency. It seems to me that how we are with our clients is more important than what we do with them. “Surrendering” well to every specific situation with every individual client seems to me to be one of the key points for change in psychotherapy.

“I am so tired. I have no hope. It seems I have lost my competencies. I even feel I am losing myself”. When this is the therapist’s experience with the depressed client, it’s just great! The change is already happening! The biggest challenge for helping professionals is to stop trying to help the suffering person in front of them. “Nature heals, and the doctor entertains the patient in the meantime” counts for psychotherapy too. By trying to help our clients, we often stand in the way of the natural healing processes. We psychotherapists are in fact paid for not trying to help the suffering person in front of us, we are paid for what we do not do. We are trained to tame our instinctive reactions in order to be in the therapy situation without aiming and expecting, and at the same time to be able to actively transform the way we are present into a free and joyful surrender to the hope inherent in the situation itself.

I am offering here this situation perspective because I believe it offers important consequences for clinical practice. I do not claim this perspective is somehow superior to other perspectives, the ones that conceptualize their help to suffering clients as a way of symptom relief, system restructuring, or dialogical co-creation of a corrective experience. I believe the situation perspective can bring into current psychotherapy an emphasis on humility in the face of healing processes which transcend the invited individuals.

References

- Anderson, Harlene. 1997. *Conversation, Language, and Possibilities: A Postmodern Approach to Therapy*. New York: Basic Books.
- Beisser, Arnold. 1970. "The Paradoxical Theory of Change." In *Gestalt Therapy Now*, eds. by Joen Fagan and Irma L. Shepherd. New York: Harper.
- Brody, Eve M. and Farber Barry A. 1996. "The Effects of Therapist Experience and Patient Diagnosis on Countertransference." *Psychotherapy* 33, 3: 372-380.
- Buber, Martin. 1937. *I and Thou*. Edinburgh: T. & T. Clark.
- Cain, Noël R. 2000. "Psychotherapists with Personal Histories of Psychiatric Hospitalization: Countertransference in Wounded Healers." *Psychiatric Rehabilitation Journal* 24, 1: 22- 28.
- Coyne, James C. 1976a. "Depression and the Response of Others." *Journal of Abnormal Psychology* 85: 186-193.
- 1976b. "Toward an Interactional Description of Depression." *Psychiatry* 39: 28-40.
- Deutsch, Connie J. 1984. "Self-reported Sources of Stress Among Psychotherapists." *Professional Psychology: Research and Practice* 15, 6: 833-845.
- Ebertová, Lucie. 2016. *Zvládající strategie terapeutů při práci s depresivními klienty*. Diplomová práce. Bmo: Masaryk University.
- Eliot, Thomas S. 1971. *Four Quartets*. London: Harcourt.
- Evans, Ken. 2007. "Living in the 21st Century: A Gestalt Therapist's Search for a New Paradigm." *GestaltReview* 11, 3: 190-203.
- Evans, Ken and Gilbert Maria. 2005. *An Introduction to Integrative Psychotherapy*. Houndmills: Palgrave Macmillan.
- Francesetti, Gianni. 2015. "From Individual Symptoms to Psychopathological Fields. Towards a Field Perspective on Clinical Human Suffering." *British Gestalt Journal* 24, 1: 5-19.
- Francesetti, Gianni, Gecele, Michela and Roubal Jan. 2013. "Gestalt Therapy Approach to Psychopathology." In *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*, eds. by Gianni Francesetti, Michela Gecele and Jan Roubal, 59-75. Milano: Franco Angeli.
- Francesetti, Gianni and Roubal, Jan. 2013. "Gestalt Therapy Approach to Depressive Experiences". In *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*, ed. by Gianni Francesetti, Michela Gecele and Jan Roubal, 433-494. Milano: Franco Angeli.

- Gallese, Vittorio and Goldman Alvin. 1998. "Mirror Neurons and the Simulation Theory of Mind-reading." *Trends in Cognitive Sciences* 2: 493-501.
- Gergen, Kenneth J. 1992. "Towards a Postmodern Psychology." In *Psychology and Postmodernism: Inquiries in Social Construction*, ed. by Steinar Kvale. London: Sage.
- Gilroy, Paula J., Murra, Jennifer and Carroll Lynne. 2002. "A Preliminary Survey of Counselling Psychologists' personal experiences with depression and treatment." *Professional Psychology: Research & Practice* 33, 4: 402-407.
- Gotlib, Ian H. and Robinson L. Anne. 1982. "Response to Depressed Individuals: Discrepancies Between Self-report and Observer-rated Behavior." *Journal of Abnormal Psychology* 91: 231-240.
- Greenberg, Leslie S. 2006. *Emotion-focused Therapy for Depression*. Washington DC: American Psychological Association.
- Gurtman, Michael B. 1986. "Depression and the Response of Others: Reevaluating the Reevaluation." *Journal of Abnormal Psychology* 95, 1: 99-101.
- Gurtman, Michael B., Martin, Kathryn M. and Hintzman Noelle M. 1990. "Interpersonal Reactions to Displays of Depression and Anxiety." *Journal of Social and Clinical Psychology* 9: 256-267.
- Hatfield, Elaine, Cacioppo, John T. and Rapson Richard L. 1993. "Emotional Contagion." *Current Directions in Psychological Sciences* 2: 96-99.
- Jenaro, Cristina, Flores, Noella and Arias Benito. 2007. "Burnout and Coping in Human Service Practitioners." *Professional Psychology: Research and Practice* 38: 80-87.
- Joiner, Thomas E. and Katz Jennifer. 1999. "Contagion of Depressive Symptoms and Mood: Meta-analytic Review and Explanations from Cognitive, Behavioral, and Interpersonal Viewpoints." *Clinical Psychology and Science Practise* 6: 149-164.
- Le Doux, Joseph. 1996. *The Emotional Brain: The Mysterious Underpinnings of Emotional Life*. New York: Simon & Schuster.
- Levenson, Hanna. 2013. "Time-Limited Dynamic Psychotherapy: Working With Reactions to Chronically Depressed Clients." In *Transforming Negative Reactions to Clients. From Frustration to Compassion*, eds. by Abraham W. Wolf, Marvin R. Goldfried and J. Christopher Muran, 191-219. Washington DC: American Psychological Association.
- Lewin, Kurt. 1951. *Field Theory in Social Science: Selected Theoretical Papers*. New York: Harper.

- Marks, Terry and Hammen Constance L. 1982. "Interpersonal Mood Induction: Situational and Individual Determinants." *Motivation and Emotion* 6: 387-399.
- Melnick, Joseph and Nevis Sonia M. 2018, in press. *The Evolution of the Cape Cod Model. Gestalt Conversations, Theory, and Practice*. Siracusa: Gestalt Therapy Book Series, Istituto di Gestalt HCC Italy Publ. Co.
- Paukert Amber L., Pettit Jeremy W. and Amacker Amanda. 2008. "The Role of Interdependence and Perceived Similarity in Depressed Affect Contagion." *Behavior Therapy* 39, 3: 277-85.
- Perls, Frederick, Hefferline, Ralph F. and Goodman Paul. 1951. *Gestalt Therapy: Excitement and Growth in the Human Personality*. New York: Julian Press.
- Rahn, Ewald and Mahnkopf Angela. 2000. *Psychiatrie: učebnice pro studium a praxi*. Praha: Grada.
- Ramseyer, Fabian and Tschacher Wolfgang. 2011. "Nonverbal Synchrony in Psychotherapy: Coordinated Body Movement Reflects Relationship Quality and Outcome." *Journal of Consulting and Clinical Psychology* 79, 3: 284-295.
- Robine, Jean-Marie. 2011. *On the Occasion of an Other*. Gouldsboro, ME: Gestalt Journal Press.
- Roubal, Jan. 2007. "Depression. A Gestalt Theoretical Perspective." *British Gestalt Journal* 16, 1: 35-43.
- 2015. "Depressing Together. Therapist's Experience in a Therapy Situation with a Depressed Client." In *Absence is the Bridge Between Us. Gestalt Therapy Perspective on Depressive Experiences*, ed. by Gianni Francesetti, 205-224. Siracusa: Istituto di Gestalt HCC. Italy Publ.Co.
- Roubal, Jan, Francesetti, Gianni and Gecele Michela. 2017. "Aesthetic Diagnosis in Gestalt Therapy." *Behavioral Sciences* 7, 4.
- Roubal, Jan and Rihacek Tomas. 2016. "Therapists' In-session Experiences with Depressive Clients: A Grounded Theory." *Psychotherapy Research* 26, 2: 206-219.
- Siegel, Daniel J. 2012. *The Developing Mind: How the Relationships and the Brain Interact to Shape Who We Are*. New York: The Guilford Press.
- Spagnuolo Lobb, Margherita. 2013. *The Now-for-Next in Psychotherapy. Gestalt Therapy Recounted in Post-Modern Society*. Milano: Franco Angeli.

- Strack, Stephen and Coyne James C. 1983. "Social Confirmation of Dysphoria: Shared and Private Reactions to Depression." *Journal of Personality and Social Psychology* 44: 798-806.
- Thompson, Evan. 2001. "Empathy and Consciousness." *Journal of Consciousness Studies* 8, 5-7: 1-32.
- Winer, Deborah et al. 1981. "Depression and Social Attraction." *Motivation and Emotion*, 5: 153-166.
- Wolf, Abraham W., Goldfried, Marvin R. and Muran J. Christopher. 2013. "Introduction." In *Transforming Negative Reactions to Clients: From Frustration to Compassion*, eds. by Abraham W. Wolf, Marvin R. Goldfried and J. Christopher Muran, 3-18. Washington DC: American Psychological Association.
- Wollants, Georges. 2007. *Gestalt Therapy: Therapy of the Situation*. Tumbout: Faculteit voor Mens en Samenleving.
- Yontef, Gary M. 1993. *Awareness, Dialogue and Process: Essays on Gestalt Therapy*. Highland, NY: Gestalt Journal Press.

CHAPTER FOUR

THE UNCANNY AS ATMOSPHERE

THOMAS FUCHS

1. Introduction

What is the uncanny? At the beginning of the twentieth century, the psychologists Ernst Jentsch (1995) and Sigmund Freud (1970) attempted to explain this phenomenon. Jentsch saw the basis of the uncanny in the uncertainty which affects us in the face of the strange or unfamiliar. In particular, this applies to the “doubt as to whether an apparently living being really is animate and, conversely, doubt as to whether a lifeless object may not in fact be animate” (Jentsch 1995, 11). We may think of dark figures on a nocturnal forest path, wax figures in a museum, a person who turns out to be machine, as in E.T.A. Hoffmann’s stories, or finally the cadaver, the vampire, or the undead. The wavering of the impression between the living and the dead produces a characteristic shudder, a horror: the reliable border between the two realms begin to blur.

Freud, for his part, cites one of Schelling’s definitions in his study: “one calls uncanny all that which should have remained in secret, hidden, but which has come to light” (Schelling 1990, 649; my translation)—and he himself sees in the uncanny “that kind of frightful thing, which returns to the old familiar, the long since known”. These are often, according to Freud’s conception, repressed infantile complexes—such as castration anxiety or the desire to return to the womb. In Hoffmann’s *The Sandman*, for instance, it is the idea of tearing out eyes which triggers a repressed castration anxiety in the reader. Freud generalised these interpretations into a theory of the uncanny as “the return of the repressed”: Shuddering is caused by what we have thought to be long overcome, or what has become unconscious, but which we meet again unexpectedly, and thus “forces on us the idea of something fateful and unescapable where otherwise we should have spoken only of ‘chance’” (Freud 1974, 237).

The uncanny thus has a close relationship with *repetition compulsion* in Freud's conception, which does not appear here as an internal compulsion, but rather confronts the subject from the outside world—as the “other of itself” (Hegel 2010, 97). The alien proves itself as ambiguous and thus lets the hidden self appear.¹ Thus, according to Freud, a particular occasion for the uncanny is also the encounter with one's self and one's own past, in other words, the phenomenon of the “double” (*Doppelgänger*):

The subject identifies himself with someone else, so that he is in doubt as to which his self is, or substitutes the extraneous self for his own. In other words, there is a doubling, dividing and interchanging of the self. And finally, there is the constant recurrence of the same thing the repetition of the same features, or character-traits or vicissitudes, of the same crimes, or even the same names through several consecutive generations (Freud 1974, 234).

Jentsch's and Freud's interpretations do not exclude one another. If we bring them together, the uncanny lies on the one hand in the power of death, threatening life, and, on the other, in the power of the past, opposing our freedom and suspending the openness of the future as doom; in particular, in the recurrence of the same, that which refuses the uniqueness of our life story. The uncanny is therefore the dead and mechanical, as well as the past and the blindly-necessary, which suddenly appear in the living, the present, and the spontaneous.

These analyses are certainly revealing in terms of the situations and motives, which lay the foundations of the uncanny. However, in their concretising approach they skip the finer phenomenological analysis of the phenomenon, which should undoubtedly be based on the *atmospherical*. In the following, I will give a broad sketch of such an analysis and then devote myself paradigmatically to a particular phenomenon of the uncanny, namely the delusional mood in developing schizophrenia. Finally, I will address the question of whether, and to what extent, the atmosphere of the uncanny can be ascribed a quasi-objective existence in certain spaces and situations.

¹ On this, see also Fuchs (2017).

2. Towards a phenomenology of the uncanny

a) The uncanny as ambiguity

Generally, we experience the uncanny (German: *das Unheimliche*) if a previously familiar environment or a known object assumes an alien, enigmatic or opaque character. Deriving from German etymology, we can claim that *das Heimliche* (the private, secret), also in the sense of *heimisch* (homely, familiar, belonging to one's home), undergoes an alienating transformation and becomes a strange, seemingly ghostly place. It creates an atmosphere of threat and sinister forebodings, which nevertheless refuses to concretise into a circumscribed, objective danger. The situation remains in an ambiguous status between normality and alienation. Yet it is this very ambiguity which creates the situation's ominous, uncanny character.

The uncanny thus lies in a particular, viz. fluctuating relationship of foreground and background: the threat does not emerge as such, but is rather anticipated or guessed at through ambiguity, namely through an ambiguity of the foreground. Therefore, the phenomenon often occurs when the field of perception is characterized by undefined, blurred structures, such as twilight, fog or darkness, in which subtlety and ambiguity reside particularly easily. In a Gestalt psychology study of beginning schizophrenia, Klaus Conrad describes how the uncanny comes over a man on a nocturnal walk in the forest:

It hirks in the dark, where one cannot see it, behind the trees one does not ask what it is that hirks there. It is something wholly undeterminable, it is hirling itself. The *interspaces* between the visible, and the *beyond*, all this intangibility is no longer reassuring, and the background itself, from which tangible things stand out, has lost its neutrality. It is not the tree nor the shrub which one sees, the rustling of the tree tops nor the screeching of the little owl which one hears, which makes us quake, but rather all that is in the background, the whole surrounding space, from which the tree and the shrub, rustling and screeching stand out. It is precisely *the dark and the background themselves* (Conrad 1992, 41).

Because things oscillate between the foreground and background, and the ominous meaning which they emanate may not be concretised, they frequently take on a shadowy, unreal character. If this character captures the entire environment, a general experience of derealisation may develop, as is often the case in the so-called delusional mood of beginning schizophrenia:

Wherever one looks, everything already looks so unreal. The entire surroundings, everything becomes strange, and one has extraordinary fear [...] somehow everything is suddenly there for me, staged for me. Everything around you suddenly relates to yourself. One stands in the centre of a play like in front of backdrops (Klosterkötter 1988, 69; my translation).

It is the task of psychopathology to distinguish this uncanny alienation of the familiar from a seemingly similar phenomenon, namely the derealisation in severe depression: here the expressive characters fade, things appear dull, colourless and insubstantial, and sympathetic bodily resonance with surroundings is lost. This produces not the frightening atmosphere of the ambiguous uncanny, but rather emptiness, lifelessness and the loss of all meaningfulness. We will return to psychopathological analyses later on.

b) The uncanny atmosphere

That the uncanny represents a particular form of spatial atmosphere is already clear from the considerations above. The atmosphere of uncanny situations can also be described in the terminology of the German phenomenologist Hermann Schmitz as a “centripetal excitement”. To designate this atmosphere, Schmitz introduces the word *Bangnis* (fearfulness), whereby he distinguishes it from fear as intentional feeling and from anxiety as a primarily bodily constriction. *Bangnis* is, then, the “atmospherically encompassing, undivided whole of the uncanny” (Schmitz 1981, 283; my translation) which advances centripetally towards the subject. Thereby the atmosphere does not appear abruptly, but rather creeps in, for ominous things at first only shine vaguely through the familiar. *Bangnis* becomes a *horror*, however, if the uncanny atmosphere condenses around certain objects and, at the same time, becomes physically threatening to the subject, thereby being connected to anxiety. Horror is therefore an “ambiguous excitement, in which an atmospherically deliquescent [...] *Bangnis* cooperates equally with isolating, fixing, and constricting anxiety” (Schmitz 1981, 288; my translation).

Timidity or fearfulness (*Bangnis*) in the face of the uncanny is bound up with typical bodily feelings, above all with shuddering, quaking or shivering, in which something “cold runs down one’s back” or “ruffles one’s hair”. Our skin and sense of warmth, that is, the sensitive surface of the body, are thus special resonance organs for the uncanny atmosphere. Closely linked to this is intermodal sensory perception, with which the

weather or the *climate* is also perceived. It is for this reason that one also speaks of “feeling”, “scenting”, or “smelling” the uncanny.²

The ambiguity, or the fluctuation, of the situation between familiarity and strangeness encourages a further reaction, namely *fascination*: the uncanny is often experienced with a mixture of terror and curiosity. The flight tendency of fear is opposed to a component of expectant tension, which makes it difficult to break away from the uncanny impression. It is not necessary to explain this fascination psychoanalytically, namely through repressed infantile, instinctual desires which supposedly break through in the said fascination by the uncanny, as if the scared person secretly wished for the terrible event. Rather, we should think of the gestalt psychological comparison with a picture puzzle or a difficult riddle, which stimulates the tendency of perception towards coherence and in which attention is stretched to the utmost. Thus, in the face of the uncanny, we also want to know what “hides behind”, and this urge for clarification at least equals the fear of concrete terrors.³

c) The intentionality of the uncanny

What is it, then, that is suspected, divined, or, indeed, feared in uncanny situations? That which is invisible and cloaked is not neutral by nature; it ultimately it always carries the character of a hidden and concealed intentionality, a threatening *power* pervading the vicinity, the eventual appearance and actions of which are already anticipated. This intentionality can be experienced as a superhuman-numinous power and so become a kernel of the experience of the demonic or divine. Rudolf Otto describes this as *Mysterium tremendum*: “it first begins to stir in the feeling of ‘something uncanny’, ‘eerie’, or ‘weird’. It is this feeling which, emerging in the mind of primitive man, forms the starting point for the entire religious development in history” (Otto 1923, 15). But the uncanny can also concretise itself in the form of mythical figures: for the “boy in the bog” in Annette von Droste-Hülshoff’s ballad, nocturnal silhouettes are personified in figures from his legendary world: the “ghostly grave

² Sensing a certain weather combines visual and acoustic impressions (for example clarity or mist, the noise of the wind or silence), olfactory, thermal and tactile sensations (smell, warmth, humidity and smoothness of the air) as well as general bodily feelings (stimulating freshness, oppressive sultriness) into an atmospheric whole. The same applies to atmospheres that one feels, for example, on a bright day at the Mediterranean Sea, in a Roman basilica or in a roaring football stadium.

³ In English, one finds the proverb: “Better the devil that you know than the devil that you don’t”.

digger”, the “spinning Lenore”, or the “damned Margaret”. In Maupassant’s *Horla* the protagonist becomes the victim of a thickening atmosphere of terror which increasingly personifies itself in the figure of an incubus:

A sudden shiver ran through me, not a cold shiver, but a shiver of agony, and so I hastened my steps, uneasy at being alone in the wood, frightened stupidly and without reason, at the profound solitude. Suddenly it seemed as if I were being followed, that somebody was walking at my heels, close, quite close to me, near enough to touch me. I turned round suddenly, but I was alone. I saw nothing behind me except the straight, broad ride, empty and bordered by high trees, horribly empty; on the other side also it extended until it was lost in the distance, and looked just the same terrible. (Maupassant 1909, 233)

Emptiness works here not as something reassuring, but rather as all the more horrific, because the perceived follower withdraws from view: the uncanny is in the position to attach itself even to the empty space, and thus it triumphs over the visible. Indeed, the uncanniness increases with the invisible-ubiquitous presence which accrues to the anonymous power all the more as it hides itself and its true nature, leaving its true intentions in indeterminacy. In this respect, Schelling’s (1990) formulation—“one calls uncanny all that which should have remained in secret, hidden, but which has come to light”—is not entirely applicable: the terrible thing, once *emerged*, may cause fear, terror, or horror, yet in its manifestation it has already shed the character of the uncanny. The uncanny is the intangible, the *nameless*. Accordingly, in the history of religion, the numinous is usually protected by taboos, or the prohibition of naming or pictorial images, so as to hinder a reification of its aura.

The motif of the hidden intentionality of transpersonal power can also be found in the form of the uncanny as described by Freud, which does not spring from the atmosphere of the environment, but rather from a fatal chain of circumstances. The uncanny is, in this sense, the coincidence of events, which create the appearance of deliberateness—such as if a rival is thought of with enmity and then dies in an accident soon afterwards;⁴ or the conspicuous recurrence of the same, which, as Freud writes, “imposes [on us] the idea of the fatal, the inescapable, where otherwise we would only have spoken of ‘chance’” (Freud 1974, 237). Once again, the uncanny effect is based on ambiguity: in one’s experience, the events oscillate between manifestly contingent *facticity* and latent *intentionality*, which emerges, as it were, “behind” the events. Disastrousness is, then, no longer

⁴ See Freud (1974, 239).

blind fate, but rather becomes something intended, such as the effect of an imprecation or a “curse”.

d) The psychogenesis of the uncanny

The latter example points further towards another vacillation, also characteristic of the uncanny, namely between the different stages of psychogenetic development, which Freud highlights in his analysis.⁵ Our acquired rational worldview, which has established *chance* as the central principle for neutralisation of significant events, is called into question by the occurrence of irritating coincidences. A not completely subdued animistic view, which is still determined by the omnipotence of thoughts, the existence of magical connections and the potency of demonic forces, competes with this rational worldview. Romantic literature, above all the work of E.T.A. Hoffmann, is therefore particularly abundant with uncanny motives, because it is situated at the intersection of a magical-mythical understanding of the world and the rational worldview of the Enlightenment.⁶

In contrast, when going back to the world of fairy tales, the uncanny effect of wish fulfilments, secret forces, and repetitions vanishes. For the fairy tale has, as Freud writes, “left behind [the world of reality] from the very start, and the animistic system of beliefs is frankly adopted” (Freud 1974, 250). The uncanny does not have a place in a world full of wonder, because it feeds itself precisely from a cognitive dissonance, an ambiguity of meanings. Besides, in this respect it resembles a phenomenon which it is initially wholly opposed to, namely the joke, which also gains its effects from the sudden shift of meaning.

Thus, the uncanny is also caused by the endangering of a worldview in which rationality has erected reliable order structures against the darkness, chaos, and deliquescence of the mythical-animistic world. It is aroused by the recurrence of what was thought to be already overcome, but what still lurks in the interspaces of the world of constant, distinct objects and calculable causal relationships, both threatening and fascinating at the

⁵ See Freud (1974, 240).

⁶ This could be supplemented by a psychological history of the uncanny. A corresponding indication is found in the etymology of the English word “uncanny”, which was first used in the sense of “supernatural” in 1773 (see Merriam-Webster Dictionary, www.merriam-webster.com). Originally it is derived from the Anglo-Saxon stem *ken* (knowledge, cognition) and from *canny* (clever, witty); the “uncanny” is therefore what goes beyond rational, scientific comprehension, and appears as soon as this has been established as a dominant worldview.

same time. Jentsch's paradigmatic wavering of impression between the living and the dead also derives its uncanny effect from the imminent dissolution of the borders that we draw up between the animate and inanimate world since early childhood. Finally, we also experience as uncanny the encounter with a mad person, for he is no longer master of himself: a foreign, demonic power seems to have taken possession of him and now speaks through him, so to speak, thus questioning our belief in the power of reason.

As we can see, the uncanny always refers to an ambivalence and fragility in ourselves. The ambiguous and inscrutable things that confront us in the world mirror an inner conflict, resulting from the latent continuance of animistic thinking under the surface of our rational understanding of the world. Once established, reason, autonomy and self-control remain endangered nevertheless, and are especially threatened by a loss of self. In Robert Louis Stevenson's *Dr Jekyll and Mr Hyde*, a descendent of Romanticism, we see the uncanny as the alternating pattern of light and dark sides taking place in the protagonist. It is precisely through a triumph of scientific rationality—he discovers a drug which separates evil from good—that he is able to generate his nocturnally instinctual alter ego, an uncanny *Doppelgänger* to whom he himself eventually falls prey.

3. The uncanny in the delusional mood

Following these general analyses, in the third section I want to examine the threat to the self caused by beginning psychosis as one of the most succinct phenomena of the uncanny. Karl Jaspers describes the characteristic “delusional mood” or “delusional atmosphere” at the onset of schizophrenia as follows:

Patients feel uncanny, and there is something suspicious about. Everything gets a *new meaning*. The environment is somehow different not to a gross degree perception is unaltered in itself, but there is some change which envelops everything with a subtle, pervasive and strangely uncertain light. A living-room which formerly was felt as neutral or friendly now becomes dominated by some undefinable atmosphere. Something is in the air which the patient cannot account for, a distrustful, uncomfortable, uncanny tension invades him [...] This general delusional atmosphere with all its vagueness of content must be unbearable. Patients obviously suffer terribly under it, and to reach some definite idea at last is being relieved from some enormous burden (Jaspers 1963, 98).

Jaspers describes the atmospheric change impressively, but without closer phenomenological analysis. In order to prepare such an analysis, I provide the description of a patient at the beginning of her psychosis.

She claimed to have been experiencing a disturbing change in her surroundings for some time. Everything appeared to be unreal to her, as in a foreign country. "I had the feeling, as if it were no longer my previous surroundings [...] as if someone had set the whole thing up like a backdrop or a show. I often touched the walls in order to see if they were genuinely real." On the street, it seemed to her, the people went as if in a puppet theatre. Many would have appeared to have looked at her meaningfully, as if they had something they want to suggest to her. On the grass in front of her house, the leaves appeared to have been ordered in a particular manner, so that she came to think that someone could have installed some kind of magnetic field in order to give her a signal. It all seemed increasingly scary to her. One week earlier, during the shopping, she was increasingly thrown into anxiety: "Outside, everything looked so peculiar and somehow eerie—as though a war would soon break out. At the weekly market, the cheap offers were barely in demand, which I found striking. I studied the interiors of the parked cars, it looked like a staging with various props. Cars drove by as if they were fleeing from something; everything made me extremely anxious. The licence plates were a signal for something that I had to decrypt. I searched for a kind of code [...] there must have been a fixed point in the whole thing. Suddenly, I began to notice the red cars more than the other colours. The order red-blue-red is, I noticed, comparable with arteries and veins. Also, the yellow cars were important as they are the colours of the nerves. White cars stood for the cells in the brain. Then it was as if the scales fell from my eyes: something terrible must have happened to my boyfriend. Someone wanted to let me know that he was in hospital, perhaps he had had a stroke..."

In the episode, the patient developed delusions of an enemy power, infiltrating the country and subjecting herself and other people to a form of mind control, in order to turn them into docile tools. She was already planning to take her own life, but she was brought by friends to the psychiatric clinic on time (report of one of my patients).

Here we meet the typical characteristics of the uncanny atmosphere as they have already been described. The inconspicuous situation has changed in a strange way, taking on an indefinite, mysterious significance, a threatening physiognomy. Everything appears externally unchanged and yet "different", specifically unreal, cryptic, and arranged, indeed, virtually

staged for the patient. Random connections or arrangements, such as the leaves on the grass, are grouped into and associated with meaningful patterns, and the principle of coincidence or chance, which could have neutralised these connections, is rendered inoperative.

The patient gets into a state of increasing expectation, something monstrous seems to be imminent. Everything points to a “beyond”: to a hidden intention that does not allow itself to be recognised; to a signal that must first be deciphered. The traffic and its directions, which are constantly emerging anew and crossing the field of perception, increase the confusion. In her distress, the patient searches for an “Archimedean point” by which she can orient herself, a point which could once again give her foundation under her feet. Here, suddenly, the colour red comes to the fore and connects itself almost immediately with a chain of new meanings—someone wants to show her that something has happened to her boyfriend. The patient experiences this meaning or coherence-building as a portent of immediate evidence, as “delusional perception”, as it is called in psychopathology; it becomes the basis for the further development of the delusion.⁷

Even if this description of the delusional mood applies, it is difficult to make the experience of the patient comprehensible. Let us imagine that we accompany the patient during the course of her day: we reach a lively, urban place in bright sunlight, the traffic flows past, people walk, wave, and converse. Meanwhile, the patient becomes ever more anxious, and to our questioning, she answers that something is wrong, something terrible is going on, and our reassurance that we do not know what she means, would only convince the patient that we are, at best, clueless, if not even involved in the alleged conspiracy ourselves. We cannot comprehend the uncanny, centripetally-directed atmosphere in which she is embroiled. And yet for the patient it means nothing less than bringing her entire existence into question.

Evidently, a transformation of her experience has taken place, one which is not ascertainable in usual psychological terms. Similarly, the assumption that the patient must suffer from particularly acute anxiety or panic is no longer valid, because the course of her illness, as well as the beginning psychosis in general, clearly show that the enigmatic-strange transformation of the perceived environment *precedes* the feelings of anxiety and threat. The mood and atmosphere of the uncanny must therefore, conversely, be traceable to a changed structure of perception itself—a change that can be described as *subjectification and fragmentation*.

⁷ On the following, see also Fuchs (2005).

Here, I draw on Husserl's analysis of perception, in which he explores the central characteristics of gestalt formation as well as the overcoming of the perspectival boundedness of perception.⁸ For example, let us consider a table. We do not see something coloured, something configured in such and such a way, nor do we see individual structures or fragments from which we then put a table together. Rather, we primarily encounter the overall shape of the table, and then, secondarily, we are able to notice the individual details or qualities of the perceived thing. Furthermore, we only ever see the table in a certain aspect, and, therefore, only single pictures or perspectives should come to us; but, in fact, we see the table *itself*. Every new aspect that I see does not bring me something new, but rather always the same object, since in every new perception I intend it itself, and the other aspects (such as the back of the table) are seen implicitly, or, in Husserl's terminology, are "appresented". It is this intentional activity of perception that allows us to grasp the object *as such*—and not only as an image or illusion. Perception overcomes its own bounded perspective by intending the object via its aspects. Things perceived are not received passively in consciousness, but are rather constituted by the act of perceiving. Thanks to this intentional achievement, perception presents the things themselves, and not only their images or simulacra.

With Heidegger we can pursue this analysis a little further: it is the intentionality of perception that also allows us to see the function and the *meaning* of the object "table" in the context of a respective situation. One does not initially see a table, a plate and food, in and of themselves, in order to then combine and interpret them as a prepared lunch, but rather the meaningful unit "a laid table" is given first. This sense of perceived things is always based on a familiarity with the world as a whole, on a "context of relevances" (*Bewandtniszusammenhang*) of all familiar things, in which the meaning of the table is also embedded. At the same time, I am myself as perceiver included in this meaningful context: I can sit at the table, the meal is prepared for me, I come in time or too late, and so forth. Perceptually, I focus on the object and I am thereby enclosed in a relationship to it. *Intentional perception constitutes units of meaning in the context of the totality of an already familiar world.*

From this basis, we can analyse the destruction of perception that takes place in the patient. With regards to its formal construction, her perception is adequate—the sensory gestalt formation remains unimpaired, as a rule, and everything "looks as ever before". What is disturbed, however, is the intentionality which is directed to an object through its aspects. The sight of the object no longer presents the object itself; with the loss of the

⁸ See Husserl (1950-1952).

appresented or “implicitly perceived” aspects, the object becomes instead a mere surface—a simulacrum, a *mise-en-scène*. It is not that what is seen seems unreal due to “psychological” reasons—in which case it would in itself be unfamiliar, alien, or incomprehensible. Rather, *perception itself* has lost its reality-constituting power. It appears subjectivised and grasps the object no longer as objective: one sees as if in a film or through a camera.⁹ Perception no longer reaches outwards, but rather stays in a solipsistic experience. In a way, the world becomes a demonstration, a hollow world of consciousness.

What happens with the context of relevances, with the significance of perceived things under these conditions? Things and people have lost their primary and familiar meanings. They are no longer embedded in a uniform context of references, but rather form nothing but singularities, isolated “erratic blocks”, as it were. The units of gestalt and contexts of meaning disintegrate, and perception appears fragmented. Individual, incoherent details and fragments are singled out of the field and come irritatingly into the foreground, without conforming to a meaningful whole. The patient herself has lost her connection to the situation and tries desperately to decrypt the supposed “signals”.

Precisely because things have lost their familiar meanings, they must mean “something else” in a mysterious way. Because they no longer stand in an accustomed context of references, there must be something uncanny about them. Their meaning can no longer lie within themselves, but rather they refer to something that they are *not*. For all their seeming harmlessness, the patient is under the impression that here “something entirely different is meant” or intended, and this other intention is directed *at herself*. The perplexity of the delusional mood is based on this experience of “meaningfulness in itself” that is, above all, detached from meaningful references and can only condense into a ubiquitous, centripetal threat.

The disturbance of form and meaning perception often also concerns fellow human beings, whose behaviour, facial expressions and gestures appear to schizophrenia patients in an uncanny way. They perceive them as conspicuous, enigmatic, and staged. Instead of identifying the real

⁹ Some schizophrenia patients literally describe their alienated perception like that: “I saw everything I did like a film camera”, “I was myself a camera. The view of people that I obtained through my eyes were being recorded elsewhere to make some kind of three-dimensional film” (Sass 1996, 286). “For me it was as if my eyes were cameras, and my brain would still be in my body, but somehow as if my head were enormous, the size of a universe, and I was in the far back and the cameras were at the very front. So extremely far away from the cameras” (De Haan and Fuchs 2010, 329–330).

others, perception only presents an independent, detached expression that thereby takes on an unreal character. This is the basis of the common schizophrenic *misidentification* of people: the previously familiar face of a relative or acquaintance appears as a mask or grimace; not infrequently, the patient believes he or she is dealing with actors or *Doppelgänger*. Conversely, unknown faces may appear to the patient as acquaintances; indeed, the whole of the surroundings can give the impression of being a *déjà vu* experience, as if the patient had been transferred to a former home. However, this identification, or “sham familiarity” is also based on alienation: detached from intentional perception, environmental impressions begin to oscillate enigmatically and connect with previous memories through prominent similarities.

The uncanny defamiliarisation of the world in the delusional mood thus results, so suggests this analysis, from a subjectification and fragmentation of perception itself, the illusory character of which informs perceived situations, things, and people. Superficially, they all appear to be what they are, but they deny it at the same time. The ambiguity, characteristic of the uncanny, obtains not between the living and the dead, between the natural and supernatural, the rational and the irrational, but rather between the real and the unreal, the familiar and the staged or artificial. Every expression becomes a mask, every situation an installed backdrop. Therefore, everything points to a hidden intention, an anonymous intentionality that does not allow itself to be recognised; and yet, it always concentrates on the patients. Everything seems to apply to the them, everything relates to them; *tua res agitur* is the meaning taken on by every situation.

The situation of the schizophrenic is comparable to that of a person who, without noticing, has been transported to a foreign country and who does not understand the language spoken there. They would not only perceive the expressions and gestures of the speakers more intensively, but, above all, the enigmatic meaningfulness of their “gibberish”. Since they cannot decrypt the meanings of the strange language, these meanings seem all the more related to them. In this way, even the loss of intentional reference to perceived things in the delusional mood cannot leave “neutral” things behind: where perception itself no longer intends the objects, there these things must, contrariwise, “mean”, look at, or speak to the perceiver. It is not only the threat derived from an anticipated danger that constitutes the core of psychotic angst and concretises in delusional perception, but also the overpowering already present, which results from an anonymous and ubiquitous “being seen”. The centripetally-directed atmosphere of delusional mood results, so to speak, from an *inversion of*

intentionality.¹⁰ precisely because the schizophrenic is unable to enter into an active relationship with the perceived, everything perceived relates to him. He becomes the “passive centre of the world” (Conrad 1992, 77).

Finally, let us consider the transition to manifest delusion, as shown in the case report. Like a riddle that the observer must solve, the altered perception in beginning psychosis produces massive disturbance, tension, and fear. The pressure to develop some kind of consistency and coherent meaning becomes overpowering. Finally, and often abruptly, a new construction emerges: the imposing self-referentiality develops into a certainty of threat or persecution at the hands of others, often an anonymous organisation that seeks to misuse the patient as a powerless tool for its sinister purposes. For the patients, this “unravelling” has the character of a revelation or an unmasking; the hidden meaningfulness, which had centred around them all along, is disclosed in one shock. The enigma receives a new, delusional meaning, which the uncanny had already presaged in the centripetal intentionality directed at the patient.

In delusion, the existential, one could even say, “ontological” threat experienced by the patient is only projected, and thereby supposedly made manageable, in the “ontic” sphere of intra-worldly threats, intrigues, and machinations. Conrad has aptly termed this transition to delusion an “epiphany” (*Offenbarung*).¹¹ It is characteristic of the irrefutable evidence of the new delusional interpretation that the extreme tension of doubt, helplessness, and anxiety suddenly ceases, due to a newly acquired certainty.¹² Then, all following situations and encounters are interpreted within the delusion’s closed frame of reference, and therefore the most harmless utterance can be taken as carefully camouflaged malevolence. The rigid, crystalline structure of the delusional schema thus replaces the lost meaning of the perceived world. Admittedly, the newfound coherence cannot restore unbiased relationships with others; rather, it brings the patient into an oppositional position to the environment. In the state of extreme threat, the self can only maintain itself at the cost of losing reciprocal intersubjective relationships, namely by turning to the *idios kósmos*, the idiosyncratic world of delusion.

¹⁰ Fuchs (2005).

¹¹ Cf. Fuchs (2005).

¹² See Fuchs (2005, 10).

4. Conclusion: the uncanny and the ontology of atmospheres

The uncanny can be phenomenologically described as an atmosphere of defamiliarisation which captures the affected with an overwhelming, centripetal effect. This effect places him or her in existential uncertainty, *Bangnis*, anxiety and terror precisely through its intangibility and ambiguity. It appears, at the same time, as the effect of a hidden intentionality, an anonymous, supra-personal, or numinous power whose eventual appearance and action is anticipated. I have described various situations and motifs in which this atmosphere can form and condense itself. Multifaceted, enigmatic and inscrutable situations or objects are particularly suitable to produce and nourish the impression of the uncanny. In the extreme case, however—in the quoted example of *Horla*, as in the case studies of the delusional mood—it is precisely by their complete normality and inconspicuousness that the surroundings take on an abysmal, terrifying character.

Finally, one may raise the question of what kind of ontological status could be assigned to the atmosphere of the uncanny. Is it a purely subjective, psychic experience or can we also attribute to this atmosphere a quasi-objective existence, independent of corresponding, “susceptible” people? The latter conforms to Hermann Schmitz’s conception, with which he attempts to overcome the common tendency to introject feelings, moods, and atmospheres into a psychic inner world.¹³ As a matter of fact, we know many atmospheres which are so anchored in rooms, landscapes, or situations that they not only grab us from without, but which are also experienced in a similar way by the majority of other people in the same surroundings. But what is the case with the delusional mood of the patient in the thronging public place as described in the case study? We could only ascribe to the uncanny atmosphere an existence independent of the particular, psychotic constitution of the patient if we assume the simultaneous presence of very different, even opposite atmospheres in this place. That is, we discern, on the one hand, the stimulating atmosphere of a vibrant, lively metropolitan bustle, felt by most of the people; on the other hand, the uncanny atmosphere of an enigmatic setting, as if installed by a secret director, in which an inscrutable threat emerges out of harmless inconspicuousness.

One would initially be inclined to attribute the first atmosphere to the surrounding space, and the second only to the morbidly altered perception

¹³ See Schmitz (1981, 102 ff., 137; 1995, 292 ff.; 2003, 175–204).

of the patient. However, if we take atmospheres and moods as forms of being-in-the-world, we cannot give ontological precedence to one atmosphere over the other. If we did so, the uncanny which the patient experiences would become only her idiosyncratic constitution, while we would unite with others in sharing a more or less general atmospheric experience and thus attribute to it an independent, quasi-objective status. However, even though different rooms and situations each encourage particular atmospheres and are, therefore, usually experienced in a similar way, the abysmal existential inscrutability of the environs is nevertheless a fundamentally existing possibility of experience open to anyone, available in each situation in which they become involved. This possibility exists only for beings who experience their surroundings as holistically significant, relevant to them, and who thus always live in atmospheres by which a specific, vitally significant relationship to the environment is expressed. Where this necessary attunement to the surroundings fails, there does not arise a “not-atmosphere”, but rather the atmosphere of the uncanny. Therefore, this atmosphere still manifests a particular kind of relationship between subject and environment, namely the existential relation of utter de-familiarisation.

The existence of atmospheres is, in this respect, bound to the existence or *Dasein*, and the respective being-such-and-so, or *Sosein*, of living subjects and creatures. This thesis of a *Dasein*'s and *Sosein*'s relativity of atmospheres does not place them in a psychic inner world, nor does it treat them as mere projections of psychological complexes. But neither is it a conception in which atmospheres and feelings are, as it were, existing independent of living beings, haunting them on certain occasions or in certain receptive states of mind. Rather, this conception understands atmospheres and moods as the encompassing whole of a particular, vitally significant relatedness of living beings and environment, such that this relationship is experienced in the way of affective concern, as emotion, affection, or even shock. If we understand this vital relationship as an objectively existing connection in itself, then we can certainly ascribe to atmospheres an objective existence in the world, in this sense, without conceiving of them as independent from the existence of living beings.

References

- Conrad, Klaus. 1992. *Die beginnende Schizophrenie. Versuch einer Gestaltanalyse des Wahns* (1958). Stuttgart: Thieme.
- De Haan, Sameke and Fuchs Thomas. 2010. "The Ghost in the Machine: Disembodiment in Schizophrenia. Two case studies." *Psychopathology* 43: 327-333.
- Freud, Sigmund. 1970. *Das Unheimliche* (1919). *Studienausgabe*, Bd. IV: 241-274. Frankfurt: Fischer.
- 1974. "The 'Uncanny'" (1953). In *The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Vol. 17, 219-253. London.
- Fuchs, Thomas. 2005. "Delusional Mood and Delusional Perception. A Phenomenological Analysis." *Psychopathology* 38: 133-139.
- 2017. "The Alien and the Self." In *Anthropology and Alterity. Responding to the Other*, ed. by Bernhard Leistle, 148-163. New York: Routledge.
- Hegel, Georg Wilhelm Friedrich. 2010. *The Science of Logic*. Cambridge: Cambridge University Press.
- Husserl, Edmund. 1950-1952. *Ideen zu einer reinen Phänomenologie und phänomenologischen Psychologie*. Bd. I, *Allgemeine Einführung in die reine Phänomenologie*; Bd. II, *Phänomenologische Untersuchungen zur Konstitution*. Husserliana III-IV. Den Haag: Nijhoff.
- Jaspers, Karl. 1963. *General Psychopathology* (1913). Manchester: Manchester University Press.
- Jentsch, Ernst. 1995. "On the Psychology of the Uncanny" (1906). *Angelaki* 2, 1: 7-16.
- Klosterkötter, Joachim. 1988. *Basissymptome und Endphänomene der Schizophrenie*. Berlin-Heidelberg-New York: Springer.
- Maupassant, Guy de. 1909. "The Horla, or Modern Ghosts". In *The Work of Guy de Maupassant*. New York: National Library.
- Otto, Rudolf. 1923. *The Idea of the Holy: An Inquiry into the Non-Rational Factor in the Idea of the Divine and its Relation to the Rational*. London: Oxford University Press.
- Sass, Louis. 1996. *Madness and Modernism*. Cambridge/Mass.-London: MIT Press.
- Schelling, Friedrich Wilhelm Joseph. 1990. *Philosophie der Mythologie*. Bd.II, Unveränderter reprograf. Nachdruck der aus dem handschriftl. Nachlass Ausgabe von 1857. Darmstadt: Wissenschaftliche Buchgesellschaft,

Schmitz, Hermann. 1981. *System der Philosophie*. Bd. II.2, *Der Gefühlsraum*. Bonn: Bouvier.

— 1995. *Der unerschöpfliche Gegenstand*. Bonn: Bouvier.

— 2003. *Was ist Neue Phänomenologie?* Rostock: Koch.

CHAPTER FIVE

NATURE OF THE INTERACTIONAL FIELD: PSYCHOPATHOLOGICAL CONFIGURATORS

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Empirical research in any field of enquiry must have a valid epistemological basis. This means that objects of enquiry need to be understood in terms of the nature of their constituents, stability of their structures and the assumptions held underlying them. Such understanding is essential not only in order to devise methods/tools appropriate to their research but to ensure that results are meaningful. Within psychiatry, this is a particularly important issue. This is because psychiatry occupies a somewhat unique position as a discipline. ● On the one hand, since the early 19th century it has been subsumed under medicine and organised as a branch of the medical sciences. ● On the other hand, as a discipline dealing with the assessment and management of patients with “disorders” affecting mental states and behaviours, it is immediately apparent that there are crucial differences between “psychopathology” and “pathology of anatomical structures”. Despite these differences, much of research in psychiatry continues to follow the models and directions of research in medicine. This is especially evident in empirical research driven by the neurosciences as in the proliferation of neuroimaging studies in relation to psychopathology where the assumption is that mental disorders are disorders of the brain. Such assumptions are explicitly expressed in programmes such as the Research Domain Criteria as initiated by the National Institute of Mental Health (Insel et al. 2010). However, there is a fundamental difference in the epistemological basis underlying the nature of “medical/physical” disorders and that of “mental” disorders (Marková and Berrios 2016) which raises questions concerning the validity of such empirical enterprises.

Undertaking research in psychiatry is beset by complexities that set it apart from research in medicine precisely on account of the difference in

epistemological basis. This has been expounded in detail elsewhere but essentially, because foundationally “physical” disorders are disorders of matter, research into understanding their causes, presentations and treatments depends on clarifying the anatomy and physiology of bodily systems. In turn this demands research methods that can capture the structure and function of the physical/biological world. Pathology is rooted in this concrete world. In contrast, “mental” disorders are not foundationally disorders of matter. Instead they are enacted at the level of language and behaviours whose “pathology” has a deeply hybrid root encompassing not just the material or concrete world but incorporating the complex world of “meaning” spanning the personal-socio-cultural-historical-interactional space (Marková and Berrios 2016). This is not to say that medicine is not a hybrid discipline, but simply to emphasise that psychiatry and its objects (mental symptoms and mental disorders) are hybrid at a deeper and structural level (Berrios and Marková 2015). In other words, the “pathology” as manifested by mental symptoms and disorders is itself constituted by the admixture of a material (neurobiology) element and a “meaning” (in the wider sense) element.

It is the “meaning” in the wider sense that poses the complexities inherent to research in psychiatry. Whereas empirical research aided by increasingly sophisticated technology is ideally suited to research of the material world, the same methods do not lend themselves easily to the study of “meaning”, at least not without leading to damaging reductionism and ensuing consequences to the validity of results. This has led to the argument that conceptual work should be a primary research tool, and critical to further empirical research in psychiatry (Marková and Berrios 2016).

As a step in this endeavour, this chapter concentrates on a particular aspect of “meaning” in the wider sense as a constitutional element of mental phenomena. Firstly, we briefly revisit the structure of mental symptoms and illustrate their hybrid nature. Secondly, we focus on the “meaning” element and specifically on one part of this, namely, the interactional field. We ask how, and in what ways, does interaction contribute to the “meaning” of mental symptoms? Thirdly, we discuss the implications of this for research in psychiatry.

1. Structure of mental symptoms

As the “units of analysis” of psychopathology, mental symptoms refer to the collection of clinical phenomena that are identified and named in order to make a case for a psychiatric diagnosis. Conventionally they are divided

into subjective phenomena and objective phenomena. Subjective mental symptoms are those that are volunteered by patients or elicited through questioning (e.g. depressed mood, hearing voices, feelings of depersonalisation, experiences of passivity, etc.). Objective phenomena are those that are determined by clinicians on the basis of examination as signs or behaviours (e.g. psychomotor retardation, agitation, formal thought disorder, etc.). Focusing here on subjective mental symptoms, it is evident that they form a widely heterogeneous group. Thus some symptoms seem to refer to experiences that most people can relate to such as worries, low mood or anxiety. Others however refer to more unusual or alien experiences such as feeling controlled by an external power or feelings of body distortions etc. Some relate to usual events and others incorporate fantastical or magical contents. Some seem to describe feelings, others perceptions, still others beliefs and even admixtures of all. Some symptoms are volunteered freely and others are elicited with difficulty, some are expressed readily and others with hesitation, and so on. Thus, mental symptoms as a group vary in diverse ways both in terms of their contents but also in the way in which they are expressed (Marková and Berrios 1995).

In order to try to determine the structure of mental symptoms in terms of their likely constituents and interrelationships, it is necessary to have some understanding of how these symptoms might arise. Interestingly, with a few exceptions as in the works of Sigmund Freud and the psychoanalytical schools, there has been little focus on exploring the formation of mental symptoms. As mentioned above, the current neurobiological drive in psychiatry assumes that mental symptoms arise out of distressed neural circuitry (Cuthbert and Insel 2013). However, such an assumption has not been validated and consequently it is important to look at symptom formation from a descriptive perspective. Indeed this helps to bring out the hybrid nature of mental symptoms. This has been detailed elsewhere (Berrios and Marková 2006, 2015; Marková and Berrios 2012) but in brief, for the purposes of delineating the structure of mental symptoms, we can trace the sorts of factors involved in this process.

Focusing here on subjective mental symptoms, then by definition, these are symptoms of which patients are aware. Thus, irrespective of the original trigger—whether this be a distressed organic (e.g. neurochemical/neuronal insult) or non-organic signal (e.g. trauma, loss, other stresses, etc.), there has to be some experiential change in the individual. The question then becomes, how does such an experiential change become converted into a mental symptom? It would seem likely

that in order to make sense of such change individuals will be drawing on a variety of sources. For the sake of analysis, we can divide such sources into three main areas.

Firstly, factors around the development of the experiential change will play a part. Here, in the first place, the *rate* at which this change in conscious state occurs must be important. A change in an internal state that builds up slowly, might draw on more sources such as memory, emotion, knowledge etc. to make sense of this change, than an internal state that changes very rapidly. Secondly, the particular *context* in which it happens may also influence the way in which an individual will interpret this and understand it as an experience. Thirdly, the *quality* of the change in conscious state will also play a part in how the internal state is interpreted. Something that is experienced as familiar might be more easily interpreted than something that is novel or alien which might require effort to make sense of and need additional sources (e.g. cultural factors, imagination, etc.) to construct.

Secondly, there will be sources that relate to the individual and his/her socio-cultural background. Here, factors such as past experiences, personality traits, personal biases and outlooks, levels of education, media influences, peer pressures, social contexts, language skills and many more will all be important in shaping the experiential change into an articulated 'symptom'. For example, a history of past similar experiences or knowledge of others with what seem like similar experiences might facilitate interpretation of some states such as depressed mood or anxiety. A tendency to introspection might generate more detailed and colourful expressions of some experiences. The level of education or interest in reading might determine the range of vocabulary an individual has to describe what he/she is experiencing. The family, society and culture in which the individual is brought up will help to structure and colour the interpretation he/she makes of the internal state. Thus, in a society where it is frowned upon to express feelings explicitly, it might be more likely that an emotional experience is understood and described in cognitive terms. ●r, a culture lacking in obvious ways of articulating emotional distress, might encourage descriptions of specific experiences in somatic terms such as fatigue, pain etc. In other words, in the same way that individuals will report on an external event in different ways, they will likewise interpret and make sense of changes in their conscious states according to their personality and socio-cultural background.

Thirdly, in addition to these factors, there will be interactional forces that are also important in making sense of a particular internal state. Here, for example, the dialogical encounter may be vital in contributing to the

shaping and articulation of the mental phenomenon. Thus, whether in communication with a clinician or with someone else, a nebulous, initially strange experience that the patient may have difficulty in capturing might, through the encounter itself, become crystallised into a specific “symptom” as the mutual exchange may offer descriptions or meanings which resonate with the patient. Likewise, in some cases it might be that noticing a particular response in the interlocutor (e.g. the clinician may appear more interested or understanding in relation to certain terms) might encourage the use of a specific description by a patient which subsequently becomes fixed as a symptom. Similarly, in the interaction with the environment and context, sense may be “constructed” of a particular internal experience. Furthermore, whilst here for the sake of analysis, examination is focused on how single symptoms might arise, in reality symptoms do not occur in isolation but alongside multiple other “symptoms” and variable mental state changes. Interaction with whatever else is being experienced at a time must also be important in shaping the description of the final symptom.

If we return then to the structure of a mental symptom, from the analysis above, we can represent it diagrammatically in the following way (see figure 5.1). In the first place, there has to be a neurobiological element since all mental states are realized in the brain and thus any mental activity will be underpinned by neuronal activity. This biological element will therefore be one of the constituents of any mental symptom. In the second place, we have an element that is derived from meaning, and as just detailed, this is meaning in the widest sense of the term as it will be shaped by the sorts of configuring factors identified above. This “semantic” element is therefore the other constituent of any mental symptom. Furthermore, this semantic element can be subdivided (again for analytical purposes here) into two types of configuring factors or envelopes as illustrated in figure 5.1. The first envelope represents the configuration that occurs as a result of the individual and socio-cultural forces (i.e., factors relating to personality, past experiences, education, personal biases, etc.). The second one represents the configuration that occurs as a result of interactional forces (i.e. through interaction with people, with the particular environment and/or context and with concomitant mental experiences). This latter envelope is the one that will now be dealt with in more detail. It is important to emphasise here that although the figure depicts the two envelopes as successive layers making up the “semantic” element, this is not intended to suggest that these are independent and/or successive processes of interpretation. Nor is it intended to suggest that this is part of an individualistic epistemology. It is simply to help identify the likely different factors that will be playing a part in this process.

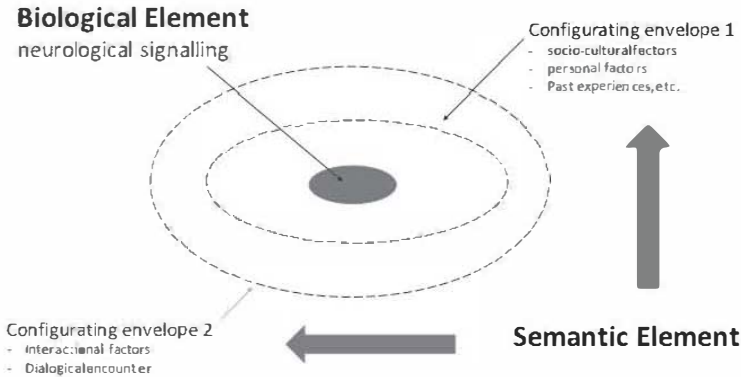


Fig. 5.1.

2. The interactional envelope

What does the interactional envelope mean? The diagram of the mental symptom structure is suggesting that interaction, together with other factors, is an important factor that will play a part in the creation of the meaning of the “symptom”. The focus now will be on unravelling this and looking at the sorts of interactions that may be important and questioning how and in what way. Since we are talking here about many different sorts of interactions and interactional factors, then this interactional envelope can be thought of as an interactional field.

Before moving on, however, it is important to clarify some basic issues around the way in which the concept of interaction is applied at this juncture. There are two perspectives we want to distinguish. In the first place, we take an interactional epistemological position. In broad terms, epistemologies can be divided into those that are individualistic and those that are interactional. The former, rooted in Platonic/Cartesian philosophy are based on the premise that knowledge, truth and meaning can be attained solely by the mind of the individual. The epistemology of René Descartes (1985) postulated rules according to which the mind operated and directed thinking towards gaining indubitable knowledge. Epistemologies based on Descartes’s ideas assume that the individual possesses innate cognitive capacities that enable him/her to search for truth and understanding of the world (including through interactions with others). These epistemologies have been and continue to be influential in underpinning the human and social sciences resulting in a position which examines cognition and its disturbances from the point of view of the

individual (for their critiques, see Harré and Secord 1972; Putnam 1988; Taylor 1995).

In contrast, interactional epistemologies, rather than focusing on the individual as the ontological unit, view the individual as intrinsically linked with the world around them. This perspective is derived from the *Naturphilosophie* of the eighteenth and nineteenth centuries, represented by scholars such as Goethe, Schelling, Fichte and Hegel. Interactional epistemologies are holistic perspectives that presuppose that organisms and their environments form unbreakable ontological units that, through their interaction, transform one another and mutually co-develop. Thus, from this perspective, it becomes meaningless to pose questions about the organism without at the same time posing questions about the relevant environment in which the organism functions. There are numerous different interactional epistemologies, which carry their own specific features. For example, interactional evolutionary biology, applied both to non-human and human species, postulates that the organism and its environment construct their specific *Umwelt* (Uexküll 1957; Chang 2009). Other interactional epistemologies are applied to humans and to their symbolic and socio-historical environments, such as pragmatism (e.g. James 1907; Mead 1934), Gestalt psychology (Duncker 1945; Wertheimer 1961; Spiegelberg 1972), phenomenologies (Crossley 1996; Merleau-Ponty 1962; Spiegelberg 1976) and Emmanuel Lévinas' (1998) ethical perspective, amongst others. Here we just want to emphasise the general position taken in this paper, namely, that the relation between the individual and his environs forms the ontological core and is the source of knowledge and meaning.

In the second place, and on the understanding that this inherent epistemological basis provides the underlying drive to "meaning" as captured by both semantic envelopes, we want to examine here, for the sake of analysis, interaction at a surface level. By this, we mean the interaction that takes place between the patient and his/her environment at a point when he/she is making sense of subjective experience. This specific focus allows us to consider individual situations and factors that can help illustrate the ways in which interaction may shape meaning for the patient at that time. It goes without saying that this is necessarily a simplification.

3. Nature of the interactional field

Moving back to our interactional field, how and in what way does interaction contribute to the meaning of mental symptoms? In order to

begin to explore this question, it is necessary to explicate what actually we mean here by the “meaning” of mental symptoms. The term “meaning” has a wide reach that encompasses notions including significance, purpose, truth, and belief, amongst others (Oxford English Dictionary 1989). Thus there are various perspectives from which mental symptoms can be examined (Marková and Berrios 2009) but for the purposes here, focus will be directed to three aspects of meaning in relation to mental symptoms.

Firstly, as figure 5.1 shows, the term *semantic* is used to refer to the meaning derived from the structural constituents of the mental symptom as described above. Since this is configured by diverse factors spanning individual, sociocultural and interactional sources, the meaning contained in *semantic* is wide in terms of its contents. However, the term *semantic* refers to the product of this configuration and this product is used in a descriptive way. The patient will articulate that they feel depressed or anxious or hear voices. These meanings are the final products of the various configurations and it is in this sense that *semantic* is applied.

Secondly, the term *sense* is used to refer to the meaning of the symptom as a whole, in terms of how it is understood and handled as a clinical and/or “research variable”. Specifically, this concerns the extent to which it acts as an “organic” (primarily inscribed in the brain) or a personally meaningful (secondarily inscribed in the brain) variable (Marková and Berrios 2015). In the context of the hybrid structure of mental symptoms, it is postulated that the *sense* of the mental symptom is carried at times predominantly by the neurobiological element and at other times mainly by the “semantic” element. For example, an organic lesion or ictal focus may give rise to hallucinations or organic anxiety. Such symptoms will not have been subject to the sorts of configurative factors described earlier. The *sense* of the symptom in these cases would be carried predominantly by the “biological” element and thus have less in the way of a meaningful connection for the individual. In other words, irrespective of how the symptom is expressed, it can be viewed as more stereotypical and relatively empty from personal significance. On the other hand, where the *sense* of the symptom is carried mainly by the “semantic” element, the meaning is important as it has a personal connection to the individual and will have been formed through the configurative forces as above. For example, in the context of depression or trauma, a person may express feelings of guilt or self-blame.

Thirdly, the term *significance* is used to refer to the meaning of the symptom when it is understood or interpreted in a “deeper” or psychoanalytic sense (e.g. as a symbol or metaphor representing underlying

conflicts or motivations of which the person may be unaware). Using the example above, someone may express feelings of guilt in the context of depression. Various sources will have been important in configuring it as such including perhaps past experiences, personality factors, recent events, interactional factors, peer pressure etc. Such factors between the individual and his/her socio-cultural environment, will, by constructing the experience, serve to connect the individual with the symptom in a deep sense. When in addition, the symptom carries a personal value, e.g. if the guilt refers to perceived failures in life as opposed to a non-specific feeling, then the connection becomes personally significant.

Returning then to the original question, namely, how and in what way does interaction contribute to the meaning making of mental symptoms, then clearly it becomes important to differentiate between the various ways in which we refer to "meaning". On account of its primacy, arguably, in the formation of mental symptoms, we are going to concentrate predominantly on the semantic aspect here.

Before moving into the realm of psychopathology, it is important to stress that interaction is an essential force in generating meaning in general—in all our experiences. The Oxford English Dictionary defines interaction as "reciprocal action; action or influence of persons or things on each other. *Spec. in Physics*, referring to the action between atomic and subatomic particles" (OED 1989). From birth, interaction with the caregiver is the means by which meaning in communication develops. Through repeated gestures, expressions, signs and language, the child learns the meaning of things (Trevarthen 1998). Throughout life there is continuous interaction with the world around us whether this is family, friends, colleagues, communities, technologies, pets, and so on. Personal, social and general meanings are constructed through such reciprocal relationships to different and varying extents. The contribution of the "other" to a particular meaning will thus vary according to context and relevance.

In relation to "pathological" mental states, this is no different. Interactions with a variety of environments social and physical will all play a part in contributing to the meaning of experiences. Thus, this interactional field is comprised of many types and levels of interactional influences. In order to try to understand how or in what ways different interactions can shape meaning, then it helps to first of all divide such interactions into those that involve co-creation of meaning and those that simply or predominantly involve influence on meaning. Clearly both are influences on meaning but the way in which this takes place is different and needs to be differentiated. We can examine these in turn.

4. Interactions in which meaning is co-created: mutual construction of meaning

At a relatively active level, we can identify interactions where the meaning of a specific internal experience can be understood as the product of the communication taking place between the patient and an “other” or “others”. We have alluded to this already in the model of symptom formation above. Here we can examine this in more detail.

As mentioned earlier, focus on interactions between the organism and its environment was of primary interest to the Romantic philosophers of the 18th and early 19th centuries such as Fichte and Hegel. The emphasis then was on various kinds of interactions and social relations among individuals, groups and institutions in terms of the co-development of knowledge, emphasis on human rights, justice and freedom (Mead 1915). Interactions were explained on the basis of the concept of the search for social recognition (Fichte 2000; Kojève 1969; Crossley 1996). Although the term “intersubjectivity” was not used, the concept was inherent in the notion of ‘the search for social recognition’ (Honneth 1995; Neuhaus 2000; Williams 1992, 1997). The term “intersubjectivity” itself came into wide use much later, probably through the work of Husserl (Spiegelberg 1976).

It was not by chance that the concept of intersubjectivity/social recognition emerged during the Romantic period in social history. It was strongly related to the emergence of the modern concept of the Self (Taylor 1975; 1989). Until the 17th century the concept of the Self was conceived as a sole centre of activity of self-knowing, self-consciousness and reflexivity (St. Augustine 1939; Descartes 1984, 1985, Berrios and Marková 2003). It was only with the development of new economic structures, political movements and revolutions in France and Americas that relations between selves and others were fundamentally changed. These new movements led to the development of social sciences and modern social practices. The relations between selves and others became of primary theoretical and ethical interest. On the one hand, relations between the self and others concerned mutuality of acknowledgement of one human being by another and these have given rise to multiple forms of intersubjectivity (e.g. Buber 2017; Mead 1934; Coelho and Figueiredo 2003; Duranti 2010; for a review see Crossley 1996). On the other hand, relations between the self and others are also asymmetric in that humans not only look to forming relations with others, but they struggle for social recognition, for power and for the objects of desires of others (Hegel 1977; Kojève 1969). Both the social concept of mutual acknowledgement and

the struggle for social recognition are historically based on Hegel's classical master-slave allegory (Hegel 1977; Neuhouser 2009). Whilst differing in various aspects, foci and dimensions, the various forms of intersubjectivity share the common premise that individuals do not develop meanings of their realities on their own but that they co-construct them mutually with relevant others (Mead 1934; Baldwin 1897). Human subjectivity is thus necessarily intersubjective (Crossley 1996).

From a clinical perspective we can explore here firstly what sort of factors may be important in the co-creation of meaning and secondly what sort of "meaning" can be attained. In terms of the first question, a number of factors are likely to be important in the co-creation of meaning. Firstly, perhaps most obviously, will be the nature of the relationship with the "other". There will of course be many "others" with whom patients will interact and who will be important in different ways in co-creating meaning. Thus, interaction can take place between patients and family members, peers/friends, strangers, professionals, authority figures, and so on. Whilst there will be asymmetry of some kind in all such inter-relationships, this will take a different form according to whether the "other" is a clinician, a family member, a stranger, a friend, etc. and hence will invoke different actions and responses in both. This is because different asymmetries will build different tensions in the participants through the differences in expectations held, in perceived roles and positions, and so on. In turn, such tensions will contribute to shaping meaning in different ways. Interaction with an unfamiliar clinician may for example give rise to conflicting needs in the patient between wanting professional help in making sense of current experience and at the same time of needing to be recognised as an equal. In turn, these patient needs will be confronting the clinician's own mixture of needs including e.g. the desire to help, the need to be effective in the face of uncertainties, etc. The resultant interaction will shape a meaning of the patient's subjective experience that will represent a negotiation between such needs. What is expressed by either of the participants and what is kept silent (hidden or unacknowledged) will be determined by such negotiation. In contrast, interaction with a close family member may provoke different sorts of conflicting needs in the patient such as wanting help on the one hand but at the same time perhaps wanting to protect the other. These needs in turn will be interacting with the mixture of needs on the family member's part, such as the need to help their relative together with the feelings of fear or helplessness or blame. Again the meaning of the patient's subjective experience will be shaped by the different sort of negotiation taking place within this specific interaction. Differences in conflicts and tensions raised

in relation to different participants of the interaction will determine what is experienced and expressed and how this is conveyed.

Secondly, the context in which the interaction is taking place will play a part with respect to the meaning that is co-created. In a situation where patients perceive themselves to be constrained or forced to obey an authoritative power, as in formal hospital detention, this may have a significant impact in relation to the communication with a perceived custodian and carry consequent effects on the ensuing co-created meaning of their experience. Communication here will be between, on the one hand, a position of perceived helplessness perhaps giving rise to feelings of hostility, lack of trust, a need to assert oneself etc. and on the other hand, a position of control and professional responsibility. This will result in an interaction that shapes meaning of the patient's subjective experience through the negotiations of the conflicts engendered through the context in which the interaction is happening. This would be different from a context where patients perceive themselves to be in an environment offering help as in an informal clinical setting. Here, the communication with someone who is perceived as trying to help, is likely to result in a different type of interaction and different sorts of negotiations resulting in a different co-created meaning of experience.

Thirdly, the nature of the pathological subjective experience itself will have a role to play in the co-construction of meaning. Here we need to take account of two things in particular. Firstly, since as already shown, mental symptoms are hybrid in structure, then the biological as well as semantic constituents need to be considered as contributing to the subjective experience of the patient. Thus, depending on the relative role of the biological element in contributing to the "sense" of the symptom, co-creation of meaning may be influenced by organic factors which can impinge not only on the patients' perceptions and interpretations of the presentations of the "others" but also on their abilities to communicate and engage with these "others". This is a factor that is unique to the "clinical" as opposed to the "healthy" communicative relation as it may independently serve to distort the communicative negotiations. Secondly, as already mentioned, symptoms do not occur in isolation and, whilst here we are concentrating on the configuration and articulation of individual symptoms, the pathological subjective experience will be composed of many different and evolving phenomena which together will be contributing to the overall subjective experience and to the way in which communication with the other takes place.

We can illustrate some of these points by considering a couple of examples in patients making sense of subjective mental states, one relating

to an experience of a familiar state but in an exaggerated or disabling form and the other to an experience of a strange/nebulous state.

In the first example, we could have someone who becomes aware of not feeling quite right but not understanding what it is or why it should be. They might seek a professional because they want to make sense of this. Through the communication and interaction with the clinician the experience may start to make sense for the patient. It gains a meaning both in the *semantic* sense, e.g. understood as anxiety, and as *significance*, e.g. understood as arising in the contexts of cumulative stresses and losses. At that point the vague experience may thus become meaningful for the individual. On the other hand, the individual might instead try to make sense of the experience whilst interacting with a family member or close friend. The communication and interaction in this instance will be different. The family member's knowledge of the patient and their background as well as the particular biases that contribute to their judgement will in their interaction be important in shaping the meaning of the patient's experience in a different way. In their specific interaction, they may focus on different aspects of the patient's subjective state and may draw on previous shared experiences (with concordant or divergent interpretations of these) as well as a jointly understood framework of reasoning. This, together with the different emotional engagement that necessarily characterises such an interaction may give rise to a mutually derived meaning of the patient's subjective experience that differs from the previous example. Here, the meaning in the *semantic* sense might be formulated as tiredness and the *significance* understood as arising in the context of perhaps one particular stressor and a family vulnerability. Different again might be the meaning arrived at in the context of an interaction with perhaps a respected colleague when the experience might also become formulated as anxiety but the significance understood as arising from excess work and lack of sleep, and so on. Clearly this is an oversimplification of the way in which interaction with different people may shape meanings since experiential changes do not arise in isolation and much will depend on the individual and the nature of the relationship between such 'others' as well as the specific contexts. Nevertheless from an illustrative perspective, this is meant to show that meanings of internal experiences can be determined to some extent by such interactions. Importantly, this is not about the "others" providing their interpretation of what might be going on for the individual (based on their experiences, knowledge, outlooks, etc.) but it is about the mutual construction of meaning—where through the dialogical exchange, utterances are selectively

expressed, suppressed, responded to, elaborated and so on—within the negotiation demanded by the specific interaction.

Similarly, in the second example, where an individual is faced with having to make sense of perhaps very alien experiences, the interaction with others may shape the meaning of such states in different ways. In this situation it becomes more complicated as the individual struggles both to make sense of his/her subjective state in a case where there may be no “templates” or reference points against which such a state can be judged and to find the appropriate terminology to capture this. Here, interactions with others may have a different orientation. For example, the alien experience may overwhelm the individual to a point where preoccupation with this can preclude a fully engaged communicative relation with the other. In this situation, one can envisage that the meaning that is arrived at through the interaction with for example the clinician may have less to do with the relationship to the clinician as the “other” and more to do with the resonance felt when expressions are uttered that might “fit” with the particular experience. Thus, whether it happens to be the clinician or someone else with whom the patient interacts may be less relevant than the significance of the words or expressions that issue out of the communicative exchange. Meaning in the semantic sense as well as its significance may become crystallised in such an interaction as might happen in the pre-delusional state.

Before moving on to the second question of this section, it is important to just briefly mention another factor that is relevant to the co-construction of meaning more generally, namely, the contribution of time. Here, for reasons of analysis, we are focusing on the interactive process at the time of symptom presentation. However, clearly interactions take place at various times, with different people and with varying frequencies. Repeated interactions with significant others at critical times are likely to have different sorts of impact on meanings than occasional interactions on less relevant occasions. In the clinical context, someone who is brought up in an emotionally abusive setting, will through their interactions over a prolonged period with a more powerful, negative other, negotiate meanings of internal states that will reflect this, e.g. fostering feelings of fear, low self-confidence, or low expectations, and, in turn, these will influence outlooks and the meanings co-constructed in relation to subsequent changes in internal states whether these are negotiated with the same or different “others”. On the other hand, meanings of internal states negotiated within emotionally secure settings are likely to have different semantic structures and equally carry a different significance. The contribution of time in relation to interactions (in terms of short-term,

long-term, intermittent, persistent, etc.) as well as context of these interactions, to the shaping of meaning is thus something that is more relevant to interactional epistemology as a whole. From the perspective of the mental symptom structure (figure 5.1), we can see therefore that it will be contributing more significantly to the formulation of meaning through the configuring factors making up envelope 1 of the semantic element. In other words, time is intrinsically relevant to the interactions that constitute the personal and socio-cultural factors that shape the meaning of internal experiences. We mention it here simply because in a sense this contribution—through interaction—is prior to the interactive process at symptom presentation but, nevertheless, will play a part in the negotiation of the latter.

The second question to examine in relation to the co-construction of meaning concerns the nature of the meaning itself. In other words, what sort of meaning can be attained through the interaction of the patient and other? Meaning can be co-created at different levels of understanding. For example, at a superficial level, during the patient-clinician interaction, patients, through the negotiations determined by the interactive process, may come to accept the clinician's terminology as appropriately capturing the description of their subjective state. The particular term, such as "dissociative symptom" may be fully accepted by the patient without a full understanding of its significance. Instead, the term "dissociative symptom" becomes meaningful for the patient more as a professional legitimization of their subjective state than as something that makes personal sense to them. On the other hand, at a different level of understanding patients and "others" will co-construct the meaning of a subjective experience, through the sorts of interactive factors mentioned above, that incorporates a deeper, more personal understanding of the experience, one that goes beyond terminological use. At yet still another level of understanding, the meaning of patients' subjective experiences as mutually derived through the interactive process reaches explanatory underpinnings that draw on deeper motivations and/or unconscious mental processes as conceived in the psychoanalytical literature.

5. Interactions resulting in influences on meaning

Interactional processes can be influential on determining meaning of internal experiences at a relatively passive level. Whereas the previous section on interactions was focusing on, broadly speaking, intersubjectivity, as the co-construction of meaning between active participants, this section deals with interactions between individuals and their environment which

shape meaning of internal experiences in a different way. Here, we are dealing with the sorts of interactions that, in effect, constitute the normal engagement with one's world but which do not necessarily involve the "active" participation of the other. The lifting of one's mood when the sun comes out or the feeling of desolation or sadness when confronted by certain news events, are examples of interactions with one's environment that can influence the meaning of internal or subjective states. Whilst views differ as to whether such interactions can be termed "intersubjective", we simply want to make a distinction between interactions that engage participants in an active sense when constructing meaning (as in the previous section) and those where interactions appear more passive in that the "other" (whether this be a person or other aspects of the environment) is not actively co-constructing meaning but is playing a part in the way that the subject constructs their meaning.

From a clinical perspective, we can see the influences on meaning through such interactions in many different ways. In a direct or literal sense, contemporary news events as broadcast through the media, such as natural disasters or terrorist attacks may be incorporated into internal experiences and thereby become part of patients' delusional contents. Less directly, interactions with the environment may influence the meaning constructed of internal states for example through changes in mood and/or focus or perspective. Thus, as described by Conrad (1958), in the early stages of psychotic illness, patients may through their interactions with the environment, construct meanings from what initially may be vague, inchoate feelings and thoughts. Such meanings may develop gradually over time as different aspects of the environment may get incorporated into their perceptions and thinking, adding to the personal significance of what is happening to them. Equally, such meanings may more quickly crystallise into a concrete significance for the patient as environmental factors may trigger ideas and thoughts in different ways. Again, as discussed earlier, it has to be remembered that mental symptoms are hybrid. Thus, in contrast to the "normal" or non-clinical situation, the contribution of possible organic factors in the interactive process will play a part in the way in which these environmental factors will be perceived, selected and interpreted. The important point however, is that making sense of changes in internal states is intrinsically linked to events and experiences in the environs.

Interactions with the environment refers to interactions with various aspects of this, including other people, noises, smells, animals, landscapes, buildings, news events, and so on. Such interactions can be either with single or simple aspects of the environment or they may involve multiple

features and their combinations. For example, someone who perhaps is feeling uneasy or anxious and who comes across a group of people talking to each other, might through that indirect interactive process, formulate a meaning for themselves in which that group of people are hostile towards them. Such meanings will arise through the interaction of the patient's mental state, personal characteristics and background together with the perceived appearance and behaviour of that group (e.g. depending on things like the age, dress, race, loudness, etc. of the group). Another person, with say a past history of physical abuse may derive a meaning of their internal state from interaction with enclosed spaces in a way that someone else with a different past experience may not. Similarly, interacting with specific smells or noises may shape the meaning of internal states very differently in those with a past history of trauma than in those without such an experience, and so on. All these interactive processes which are as much part of normal engagement with the world as in the clinical situation will influence the meanings formulated around internal states. They will vary in extent to which they are explicit and people's awareness and insight into them will likewise vary.

In recent years, the enormous advances in technologies have added new and ubiquitous interactive environmental elements. The development of ever more sophisticated computers, tablets, mobile phones and other electronic gadgets together with the expansion in internet use and social media, has resulted in a widening of the interactional field albeit, arguably, a reduction in its depth. The pattern of societal interactions has clearly been transformed. It remains a question to what extent such interactions will overtake the interactions engaging in active co-construction of meanings and what this might mean for the way in which internal states and indeed external reality become conceived and formulated.

6. Implications of the interactional field for research in psychiatry

Having examined some of the predominantly surface interactional factors that help to configure subjective mental symptoms, the next question is what does this mean for research in psychiatry? In the first place, it shows that subjective mental symptoms are not simply the direct expressions of neurobiological distress as assumed by much of empirical research underpinned by the current biological drive. Instead, as hybrid objects, subjective mental symptoms are constituted, in variable proportions, by both a neurobiological element and a "semantic" element. It is on account of the semantic element that mental symptoms will not be the sort of stable

and fixed objects of inquiry demanded by empirical studies. Here we have been focusing on one aspect of the “semantic” element, namely, the surface interactional factors that help to constitute meaning of an internal state and hence a mental symptom. What we have shown is that the meanings of mental symptoms are co-constructed and shaped through the interaction between patients and their environment. The extent to which such interactional processes will be important in the constitution of these symptoms will vary according to a number of factors, including the “sense” of the symptom (i.e. the respective roles carried by the biological and semantic elements), the particular context and concomitant psychopathology. However, the essential issue highlighted here is that on account of interactional forces, then in different contexts and/or with different interlocutors, and despite a common neurobiology, the “symptom” may be formulated in a different way. Thus, the “same” neurobiological signal could be associated with different symptoms as individuals will configure their internal states differently according to, amongst other things, the interactional effects. One person may talk about low mood, while another one complains of pain or anxiety or depersonalisation, and so on. In other words, to paraphrase Putnam (1975), subjective symptoms are not all situated in one’s head.

This carries important implications for research in psychiatry, particularly in relation to the current focus on brain localization of mental phenomena (e.g. Allen et al. 2008; Shad et al. 2012). Effectively we are saying that ‘meaning’, a constituent of mental symptoms, is co-created through and/or influenced by the interaction between patients and their environments. As such, it would make little sense to try to localise this in the brain of the patient. Identifying the neurobiology in these situations would not be sufficient to understand or explain the mental phenomenon. Sprevak (2011) has made a similar argument in relation to cognitive function, highlighting the importance of interactional effects between a person’s cognition and their contextual environment and showing that neurobiology would not be sufficient to explain specific cognitive processes. In the case of more complex phenomena such as mental symptoms, clearly the interactive effects would be greatly magnified.

Understanding the structure of mental symptoms and specifically the respective roles of the neurobiological elements and semantic elements is necessary to determine valid research approaches to their study. Where the sense of mental symptoms is carried by the neurobiological element, then it would be appropriate to continue with the research strategies that are in line with the medical model such as localization enterprises and other correlational type studies. However, where the sense of mental symptoms

is carried by the semantic element, then this line of research is unlikely to yield valid or meaningful results. Instead, we need to develop approaches that seek to understand the configuration of symptoms, ones which try to disentangle the multitude of factors that will have determined or that will be contributing to their construction as symptoms. Amongst such factors, interactional processes through the co-construction of meaning as well as through more passive influences on meaning, are key.

7. Conclusion

Whilst psychiatry has been formed as a discipline within medicine, crucially, it has a different epistemological basis from medicine. In consequence, mental symptoms have a greater epistemological role and responsibility than “medical symptoms”. As hybrid structures, subjective mental symptoms are compounds of incongruent elements, constituted by a biological element, that is neurobiological signalling on the one hand, and a “semantic” element on the other. The latter refers to the meaning of the symptom for the person, a meaning that is configured through the interplay of factors relating to the individual and their interaction with the world including their socio-cultural background, personal circumstances and experiences, educational level, family and peer supports and so on. Focusing here in more detail on the role of surface interactional factors, it is evident that the meaning of internal states will be shaped to different extents during the interactional process depending on the context in which the interaction is happening as well as on the specific relationship with the interlocutor. Different forms of asymmetries in this relationship will invoke different needs, responses and conflicts in each participant and result in differences between negotiated meanings. Consequently, the ensuing meaning of subjective mental symptoms is dependent not just on whatever is happening within the patient’s neurobiology but has a wider environmental reach. Research in psychiatry needs to take into account the epistemological basis underlying psychiatry and the hybrid structure of mental symptoms in order that approaches to the study of mental symptoms yield valid results. This may result in redirecting some focus onto the semantic constituents of mental symptoms and looking at developing different approaches to explore the various configurators of meaning.

References

- Allen, Paul, Larøi et al. 2008. "The Hallucinating Brain: a Review of Structural and Functional Neuroimaging Studies of Hallucinations." *Neuroscience and Biobehavioral Reviews* 32: 175-191.
- Augustine. 1939. *The Confessions of St Augustine*. London: J.M. Dent & Sons Ltd.
- Baldwin, James M. 1897. *Social and Ethical Interpretations in Mental Development*. London: Macmillan.
- Berrios, German E. and Marková Ivana S. 2003. "The Self and Psychiatry: a Conceptual History." In *The Self in Neuroscience and Psychiatry*, eds. by Tilo Kircher and Anthony David, 9-39. Cambridge, UK: Cambridge University Press.
- 2006. "Symptoms. Historical Perspective and Effect on Diagnosis." In *Psychosomatic Medicine*, eds. by Michael Blumenfield and James J. Strain, 27-38. Philadelphia: Lippincott Williams & Wilkins.
- 2015. "Towards a New Epistemology of Psychiatry." In *Revisioning Psychiatry. Cultural phenomenology, Critical Neuroscience and Global Mental Health*, eds. by Laurence J. Kirmayer, Robert Lemelson and Constance A. Cummings, 41-64. New York: Cambridge University Press.
- Buber, Martin. 2017. *I and Thou* (1923). London, UK: Bloomsbury Academic.
- Chang, Rosemarie Sokol, ed. 2009. *Relating to Environments. A New Look at Umwelt*. Charlotte: Information Age Publishing.
- Coelho, Nelson Ernesto and Figueiredo Luis Claudio. 2003. "Patterns of Intersubjectivity in the Constitution of Subjectivity: Dimensions of Otherness." *Culture & Psychology* 9: 193-208.
- Conrad, Klaus. 1958. *Die Beginnende Schizophrenie*. Stuttgart: Georg Thieme Verlag.
- Crossley, Nick. 1996. *Intersubjectivity. The Fabric of Social Becoming*. London: SAGE Publications Ltd.
- Cuthbert, Bruce N. and Insel Thomas R. 2013. "Towards the Future of Psychiatric Diagnosis: the Seven Pillars of RDoC." *BMC Medicine* 11: 126.
- Descartes, René. 1984/1985. *The Philosophical Writings of Descartes*. Cambridge: Cambridge University Press.
- Duncker, Karl. 1945. "On Problem-solving." *Psychological Monographs* 58, 5, whole no. 270.
- Duranti, Alessandro. 2010. "Husserl, Intersubjectivity and Anthropology." *Anthropological Theory* 10, 1-2: 1-20.

- Fichte, Johann Gottlieb. 2000. *Foundations of Natural Right* (1796). Cambridge: Cambridge University Press.
- Harré, Rom and Secord Paul F. 1972. *The Explanation of Social Behaviour*. Oxford: Blackwell.
- Hegel, Georg Wilhelm Friedrich. 1977. *Phenomenology of Spirit* (1807). Oxford: Oxford University Press.
- Honneth, Axel. 1995. *The Struggle for Recognition* (1992). Cambridge: Polity Press.
- Insel, Thomas et al. 2010. "Research Domain Criteria (RDoC). Toward a New Classification Framework for Research on Mental Disorders." *American Journal of Psychiatry* 167, 7: 748-751.
- James, William. 1907. *Pragmatism. A New Name for Some Old Ways of Thinking*. New York: Longmans, Green and Company.
- Kojève, Alexandre. 1969. *Introduction to the Reading of Hegel*. New York-London: Basic Books.
- Lévinas, Emmanuel. 1998. "Philosophy, Justice and Love." In *Entre-nous: Essays on Thinking-of-the-other*, 103-122. New York: Columbia University Press.
- Marková, Ivana S. and Berrios German E. 1995. "Mental Symptoms: Are They Similar Phenomena? The Problem of Symptom Heterogeneity." *Psychopathology* 28: 147-157.
- 2009. "The Epistemology of Mental Symptoms." *Psychopathology* 42: 343-349.
- 2012. "The Epistemology of Psychiatry." *Psychopathology* 45: 220-227.
- 2015. "Neuroimaging in Psychiatry: Epistemological Considerations." In *Alternative Perspectives on Psychiatric Validation*, eds. by Peter Zachar, Drozdostoj S. Stoyanov, Massimiliano Aragona and Assen Jablensky, 112-127. Oxford, UK: Oxford University Press.
- 2016. "Research in Psychiatry: Concepts and Conceptual Analysis." *Psychopathology* 49: 188-194.
- Mead, George H. 1915. "Natural Rights and the Theory of the Political Institution." *Journal of Philosophy, Psychology and Scientific Method* 12: 141-155.
- 1934. *Mind, Self and Society*. Chicago: Chicago University Press.
- Merleau-Ponty, Maurice. 1962. *Phenomenology of Perception*. London: Routledge.
- Neuhouser, Frederick. 2000. "Introduction." In Johann Gottlieb Fichte, *Foundations of Natural Right*, ed. by Frederick Neuhouser, vii-xxviii. Cambridge: Cambridge University Press.

- 2009. “Desire, Recognition, and the Relation Between Bondsman and Lord.” In *The Blackwell Guide to Hegel’s Phenomenology of Spirit*, ed. by Kenneth R. Westphal, 37-54. Oxford: Wiley-Blackwell.
- Oxford English Dictionary. 1989. 2nd edition. Oxford: Oxford University Press.
- Putnam, Hilary. 1975. *Mind, Language and Reality*. Philosophical papers Vol. 2. Cambridge: Cambridge University Press.
- 1988. *Representation and Reality*. Cambridge, MA-London: The MIT Press.
- Shad, Mujeeb U. et al. 2012. “Neurobiology of Self-awareness in Schizophrenia: an fMRI Study.” *Schizophrenia Research* 138: 113-119.
- Spiegelberg, Herbert. 1972. *Phenomenology in Psychology and Psychiatry*. Evanston: Northwestern University Press.
- 1976. *The Phenomenological Movement*. The Hague: Martinus Nijhoff.
- Sprevak, Mark. 2011. “Neural Sufficiency, Reductionism and Cognitive Neuropsychiatry.” *Philosophy, Psychiatry & Psychology* 18: 339-344.
- Taylor, Charles. 1975. *Hegel*. Cambridge and London: Cambridge University Press.
- 1989. *Sources of the Self. The Making of the Modern Identity*. Cambridge, UK: Cambridge University Press.
- 1995. “Overcoming Epistemology.” In *Philosophical Arguments*, ed. by Charles Taylor, 1-19. London and Massachusetts: Harvard University Press.
- Trevarthen, Colwyn. 1998. “The Concept and Foundations of Infant Intersubjectivity.” In *Intersubjective Communication and Emotion in Early Ontogeny*, ed. by Stein Bråten, 15-46. Cambridge: Cambridge University Press.
- Uexküll, Jacob von 1957. “A Stroll Through the World of Animals and Men: a Picture Book of Invisible Worlds.” In *Instinctive Behaviour: the Development of a Modern Concept (1934)*, ed. by Claire H. Schiller, 5-80. New York: International Universities Press.
- Wertheimer, Max. 1961. *Productive Thinking (1945)*. London: Tavistock Publications.
- Williams, Robert R. 1992. *Recognition: Fichte and Hegel on the Other*. New York: State University of New York Press.
- 1997. *Hegel’s Ethics of Recognition*. Berkeley-Los Angeles: University of California Press.

CHAPTER SIX

ATMOS/EIDOS: THE LIFE-WORLD BETWEEN FORM AND FORMLESS

GILBERTO DI PETTA AND DANILO TITTARELLI

The object of knowing and feeling is the truth, which is being revealed
with and within us in the encounter and relation with reality.
(Buytendijk 1964)

1. Introduction

In the century-old story of phenomenology applied to clinical psychopathology, the two conceptual milestones of atmospheric perception and eidetic insight have suffered quite different fates, even from the noun used to describe them. Indeed, atmospheric is expressed by using a term relating to the perceptual (gustatory, olfactory) dimension, whereas eidetic is expressed by using a term relating to a more properly mental dimension, i.e. intuitive (from *intu-ire*, i.e. to go/look inside with the mind) or, at least, visual (eidetic vision).

It is just as if the atmospheric could only be observed through the sensorium, and the eidetic with the mind or, rather, with the pure consciousness (the Cartesian *cogito*). Indeed, the eidetic vision refers more to the mental vision—that is, the eye of the mind—rather than to the eye vision. That is why the term “eidetic perception” is rather unknown and may sound weird.

Such different access keys of language would suggest that these two moments are radically separated. In other words, observed either through one or the other. In fact, while with the atmospheric we are to adopt, or better, to be aware of the existence of a perceptual way (i.e. a passiveness), for the eidetic we become capable of an eidetic intuition or vision, that is, we reach a position to actively envision an eidetic or noematic element. To

do this, we must actively implement the epoché,¹ and suspend the natural attitude. The epoché clears the field from any prejudice, and we can reach a consciousness cleared and ready for the insight or the eidetic vision. On the other hand, no epoché seems to be required for the atmospheric.

Once freed from the prejudicial ballast by the epoché, it is indeed our intentionality that lets us reach an eidetic vision. Therefore, the eidetic vision is the preserve of a consciousness which is deemed clear and purified, while the atmospheric perception is the preserve of feeling (*Empfinden*) and of a sensoriality that vibes freely when touched by air, wind, emotional atomisation, and spatialised feelings (Griffero 2016).

Air is something “in-between” (*aida*, Kimura 2005) the self and the world, an ubiquitous and necessary space in the middle. It affects us at an emotional and physical level and it mainly shows itself *ex negativo*, not only in claustrophobic terms. When you are “short of breath”, you want to “get some air”, take “a deep breath”, you want to back out of a lived-body distress that is not metaphorical at all, in order to feel “free as air”. Thus, you try to understand, you sense from the affective-bodily effects how you need to behave in a situation which is toned by a particular, permeating atmospheric quality. Air as climate is therefore a genuine atmospheric experience (Griffero 2013).

Therefore, according to this dual-track line, the atmospheric would not stand in the sphere of transcendental and of a pure vision of essence, and would not involve the abandonment of the natural attitude; on the other hand, the eidetic obviously does so. The atmospheric would therefore be within the reach of all, and would immediately catch the quasi-things (*Halb-ding*). It would unfold in the ontic sphere and be the preserve of an empirical ego. Indeed, everyone—some more than others—become aware of the changes in the atmospheric register (the atmosphere of a funeral rather than the atmosphere of a wedding, the Christmas atmosphere rather than the Good Friday atmosphere). Whereas the eidetic is only within the reach of those who, once properly trained and disciplined, carry out either a

¹ *Epoché* is used by clinicians with a phenomenological approach as an active and propelling tool towards their own personal life, “so not only as a diagnostic tool, but also as a *self-reflective* element of formation (*Bildung*), i.e. a radical self-questioning and, therefore, a powerful transforming agent of the *suffering and suffered* phenomenological consciousness”. Another aspect of equal importance is given by the (psycho)therapeutic repercussion of epoché on the relationship between therapist and client. With this meaning, epoché becomes the key tool for phenomenological access to the cure enabling the clinician to focus on or highlight segments of embodied unreality (Di Petta 2010).

transcendental reduction or a reduction to the life-world. Therefore, in order to further enlarge the gap between these two dimensions, one could say that the atmospheric is located in the ontic, that is, the empirical sphere, and then of the visible reality. On the other hand, the eidetic is located in the transcendental, that is, the ontological sphere, namely the noumenal or phenomenological reality; an invisible that must be brought to light, that is, brought as evidence, with exercise (Calvi, 2005) and effort.

But are things really this way?

Can it be possible that the atmospheric is not just a matter of the senses, and that the intentionality constituting the noema is not only a matter of conscience?

Is it correct to say that the atmospheric is a property of the pre-reflective, predictive, pre-verbal, while the eidetic is the preserve of the reflective, verbal, and predicative? In these terms, however, the atmospheric would also belong to the transcendental sphere, as the transcendent silently innervates the structures enabling the explication of life as we live it, and hence, also the pre-reflective sphere is transcendental. On the contrary, the transcendental fully identifies with the pre-reflective. The pre-reflective sphere (let us consider the common sense that lays upon it) is the sphere where the conditions of possibility that make life uninhibited, and that make us feel at home in the world and familiar with the others, are set. This is what is lacking in our schizophrenic patients, who are defective in engaging this transcendental, ontological field onto an empirical/ontic one.

In German psychiatry—and especially in the German psychopathological tradition—the insanity “affective motor” postulate will have inflections related to the romantic subject of “sensitivity”, and it will be apt to search that “atmosphere” phenomenon that so often announces and ushers in insanity, as Del Pistoia mentions; instead, the trend followed by French psychopathology—already with Pinel—is inclined to favour the precision of the nonsensical ideas, rather than favouring the “atmospheric” magma of anguish, derealisation, and depersonalisation in terms of genetic understanding (Tatossian 1979).²

² The difference between these two trends is almost vividly expressed by the definition of melancholy provided by Griesinger on one hand, and Esquirol on the other: respectively, *Schwermut* for the German psychiatrist (Griesinger 1865), and *délire triste* for the French (Esquirol 1838). And in these words, there is the suggestive foreannouncement of the “atmosphere” or “subject” choice (Del Pistoia 1996). Facing this obstacle, Kraepelin will try to bypass it in an attempt to convey the fleeting “atmosphere” dimension of mood in terms of psychic life “rhythm”,

This tradition has been expressed in famous subjects: from Jaspers's (1964) *Wahnstimmung* (who takes in the romantic concept of *Stimmung*, the musical "tuning" and internal rhythmicity of psychic life) to the several *Stimmungen* or "emotional pitches" described by traditional psychopathology as the pre-subject access ways in many psychopathological conditions; from Conrad's *Trema*—from which the delusional perception originates—to Janzarik's (1959) dynamic oscillations—an instability of the thymic background of the experience which even Mentzos (1967) and the Hamburg school identify as the precognitive background of first-rank phenomena; from Minkowski's autism—a loss of vital contact with the world, primary *trouble générateur*—to Blankenburg's (1998) *loss of natural evidence*; from Rümke's (1990) *precox feeling* to Parnas's *autism* and Arnaldo Ballerini's contributions to such subjects in Italy (Ballerini and Di Petta 2015). Such a tradition is prevailing in European psychopathology, dominated by the belief that cognitive aspects are secondary to a primary one that involves pre-reflective and embodied, "humoral" and affective levels of wilfulness.

On the other hand, the eidetic seems to be related to an image rather than to an abstract concept, since the vision of the perfect essence would be nothing but the grasping (*Auffassung*) of an image: but how much of the verbal is there in a picture, in the end? How much of consciousness? An image can be described by shape, colour, movement, and the heat it emits. And all those things turn out to be inseparable from the sensory attributes, such as colour, size, and spatiality. From this point of view, the less conscientious phenomenologists (Straus 1930; von Weizsäcker 1968; Merleau-Ponty 1945; and Husserl 1970) have something to say: the intentionality springs out from the flesh, rather than only from the consciousness of a pure ego. Anyway, it comes from an incarnate consciousness.

Is it also correct to say that in the human being the atmospheric perception comes before the eidetic intuition? In accordance with the hierarchy that sees perception a degree lower than true representation, it is correct. Then, what kind of perception do we consider as the atmospheric perception? Rather than taste, the key elements of the atmospheric perception are the gustatory and the savouring.³ Rather than on smell, the

which reveals the manic or melancholy alteration of mood (acceleration, slowdown), way more than sadness or euphoria, and more recently by Ballerini who identifies "eidos" of melancholy as a serious alteration of the existence temporal plot (Ballerini 2015).

³ As a diagnostic criterion, along with the atmospheric feeling, Tellenbach (2013) adds taste, which represents the foundation of a psychiatric knowledge acquirable

atmospheric perception seems to be based on the olfactory.⁴ Then perhaps, the atmospheric is not really a perception referred to a specific way of meaning, but rather a sensorium impregnated by metaphysics, dilated and vibrant, as expressed by Minkowski in *Vers une cosmologie* (1936) or by Straus in *Von Sinne der Sinne* (1930). If I say I smell a certain atmosphere or taste some atmosphere or feel a certain atmosphere, I obviously do not mean a particular smell, taste or any another particular feeling. I rather mean that “more” (Tellenbach 2013) which, of course, comes from the senses but is not properly sensory.

But, in the end, as regards the eidetic vision, when speaking of “adumbrations” (*Abschattungen*) in the description of the conscientious profiles of a given object, or of the ways in which the object appears to the eidetic understanding, perhaps Husserl does not allude to some incomplete frames overlapping with one another due to the acquisition speed over the conscientious retina of the subject, thus giving for sure something

through long experience, practical education and through a training path. The student and the psychiatrist lacking such sensitivity—Tellenbach continues would find extreme challenges in their knowledge process that would not represent a simple descriptive diagnosis based on objective data.

⁴ *Touch* is a type of sensitivity in dealing with others, hence it includes the capacity to feel an atmosphere, air, mood, environment enveloping a given situation of which you have an overall awareness (Stanghellini 2013; Stanghellini and Imbrescia 2010). From another standpoint, we can state that sensory modifications associated with symptomatic statuses of psychopathology have been clearly highlighted and we have a related broad literature and daily clinical practice. Tellenbach is undoubtedly the author who, more than others, has been able to phenomenologically describe such connections (Paduanello 2016). “Odour spreads in the air” writes Minkowski, and this aroma as Tellenbach says expands and fills the air, revealing the existence of the atmosphere and, as a sentient being or subject, the human being takes part in it. In this sense, and from a phenomenological and psychoanalytical perspective, it is a primordial experience, an experience of the motherly that the child has while being breastfed, intended as a Lacan’s amboceptor, in which all the aroma emanated by the mother and, we add, by the child itself condensates. In this enveloping atmosphere, not only what is most familiar is recognised, but also in a psychopathological sense, or rather, in terms of the psychology of what is pathological and “pathic” what is most extraneous or disturbing. Therefore, when a human being meets another human being, and from existence there is always a co-being, there will be a sensory-emanatory relationship. In this aura of motherly, the child learns to refine its atmospheric intuition and the ability to irradiate, in return, its own atmosphere, its own and human air which characterises its own individuality (Tellenbach 2013).

somewhat reduced—that is, infinitely reduced—than the clear vision of essence, but also something more. Especially more indeterminate.⁵

In short, it seems that no definition can suit us. In fact, when we move from theoretical conceptualization to the field of experience, and from here, in the world of life and the clinic, things get complicated. It is difficult to see net distinctions, while continua are perceived as better structured. In order to understand, at times we do need something else. Everything.

Maybe, we are the borderland between ontological and ontic—certainly a virtual and imaginary region, though existing somewhere—a land where belonging to either one of the two spheres is not taken for granted at all. In fact, belonging to one of them is apparently more due to the perspective one looks from, rather than to the real roots one may have in one of the two spheres.

At this point, the main idea behind this work proves that the atmospheric and the eidetic are alternating, not mutually exclusive parts of the same contact device between the subject and the world, between the ontological and the ontic, thus aimed at revealing the primordial or pre-dualistic and original bond between the subject and the world, and their co-belongingness to the generative horizon of life. Secondly, that neither the atmospheric nor the eidetic, can be strictly localised in a single apparatus (conscientious, sensory or muscular, empirical or transcendental), but rather they are the preserve of humans as living beings, in their whole relationship with the world.

Therefore, whereas the eidetic is more related to the understanding of a figure, the trajectory of a line, the atmospheric is rather related to the nebula, the field, and the chiasmatic and infinitesimal crossing of the lines. In other words, we are at the contact boundary between form and formless.

In any case, the atmospheric and the eidetic seem similar to the wave or corpuscular theory of light. In a sense, the atmospheric stands for the wave, while the eidetic stands for the corpuscular. But are they really the same? Can we say that the atmospheric is the eidetic caught in the swirling movement of life, in its field effect, or in the incarnation of the experienced movement? On the other hand, the atmospheric appears to be a field effect, a zone mark, the immediate result of a burst of eidetic details

⁵ Husserl talks about adumbrations by no chance. Husserl's term *Abschattungen* can be found in Sartre's *Immaginaire* and translated as the outlining of things. Human consciousness receives objects from the outside world in a quite efficient way through their profiles, i.e. through their protruding surfaces. However, Husserl's term is even more caustic because it contains the root of the term *Schattung*, which means "shadow". So, the contrast is the basic visionary condition of the imaginative conscience, i.e. the eidetic conscience, i.e. the lived conscience.

trapped in the trawl by enfilade. Can we say the atmospheric comes before the eidetic or, at this point, that an atmospheric quota follows or at least goes along with the eidetic, too?

We will now go through a number of clinical situations in which these two perspectives—the atmospheric and the eidetic—seem to be inseparable from each other.

2. The ‘ground-level’ encounter

This definition was created by one of us (Di Petta 2004) in order to describe the clinical situations, set up in drug addiction services. It is no coincidence that both authors have shared this working experience. In this type of service, the encounter with patients can be encoded with the Second Law of Thermodynamics, that is, the chaotic kinetics of the gaseous molecules.

They are all threshold encounters, that is, taking place in the corridors, in the street, at home or at the methadone delivery desk, where there is an inner setting only (Di Petta 2006a). The extreme geometric variability of the setting, the compromised conditions of patients’ consciousness, and the unpredictability of the request made such encounters sharp, fluttering, and often the final ones, but, above all, they were extremely direct, and with no filter at all (e.g. appointments, waiting lists, etc.). Therefore, the encounters became full contacts with the other, but at the same time they abided by the definition of the true encounter set by Buber (2014), that is, where every medium fails. Being one-shot encounters, the symmetry of the parts, the speed of the exchange, the need to say the essentials all at once, made it all very special. During these superstructure-free encounters, it was important to grasp something else, even a small detail, and send something essential back to them. The tuning, the graduation of empathy, were key elements in the process.⁶ The smell of the other came to you, and

⁶ Ludwig Binswanger (1881-1966) is the founder of *Daseinanalyse*. He was a physician, neurologist, and psychiatrist, and as such, he was inherently gifted with that sensitivity that should lead a doctor to “feel by perceiving” (Tittarelli 2015). In psychology and psychotherapy, often sensations only have been discussed, never *feeling*. The lived experience has always been considered and observed as the *gnosis moment*, but never the *pathic moment*. By pathic moment Straus means the direct communication we have of things, based on variable way they give themselves through the senses. The pathic belongs to the most original stage of lived experience, and its proven difficult accessibility via a conceptual knowledge is indeed due to the fact that we establish an intuitive-sensitive communication of a pre-conceptual kind with phenomena. Masullo (2003), for his part, proceeds in a logical and *pathic* research of a possible solution, trying to settle logos

you could almost taste it. Their ways of dressing, walking, or swallowing their words, as well as their eyes either bright and dysphoric or bleary and half-closed, were all key elements in the process. In such encounters, you could never separate the atmospheric allure from the eidetic detail. The pattern here was not like an unending (endless) chess game between a therapist and a patient, but that of a single round match, after which one of them would be eliminated. We are talking about squeezing all possible intensity into each encounter, working for hope against defeat, life against death, and trying to pierce the substance veil.

“We have ‘impressions of vitality’, just like we breathe air. Obviously when we enter into a relationship with other people, we intuitively assess their emotions and their moods, their state of health or illness, based on the vitality expressed by their movements. Movement developing during a period of time, that can be even very short, is central in vitality”. The assumption is that each moment of change involves a real unexpected experience, a shared affective journey concerning the relationship between two or more persons in a time span that is experienced like “now”. (Stern 2010)⁷

3. The Dasein-analytic group

The atmospheric is this: it is a normal Thursday afternoon, and about fifteen, sixteen women of various ages and nationalities are brought in dribs and drabs by the prison agents. They come as pilgrims, with their sweatshirts, their arms tight to the body, as if they were cold. But the inner cold is more than the one on the outside. How can one measure the temperature of solitude and nostalgia? The chairs are in a circle, an oval circle, because the room is oblong, with the benches crowded on one side. Some empty seats are left for those who are not there, that is, for those who are now free, returned to the world, leaving behind the nostalgia of their lost presence. At the centre of the circle, two empty chairs shade each

representing also the verbal aspect of intersubjective communication and *pathos*—corresponding to the *pre-verbal*, but also to the *post* and *inter-verbal* part of interhuman communication what Masullo defines as “incommunicative”, thus basically placing the cognitive element on a different level compared to the emotional one (Vetrugno et al. 2014).

⁷ Stern talks about a *phenomenology of “now”* as a present moment with a determined duration. This experience is lived by both subjects and each of them intuitively takes part in the other’s experience. This moment creates a particular form of conscience and is coded in memory, re-writing the past. In psychotherapy, such change takes place thanks to these sudden and unpredictable changes in the “way of being with others” (Stern 2004).

other: they are waiting for their encounter. After an initial silence, with a heavy twilight atmosphere and everybody giving themselves a cold hug, the moderator's voice starts speaking about sadness and how it feels to meet strangers in a suspended space, about the difficulty of meeting with oneself. Women's voices come one after the other, until silence breaks into sobs. Then, two people stand up to embrace each other. At that moment, the crunch of the gloomy pain suddenly cracks. Two bodies are touching each other for everyone: not to hurt, but to share the warmth of an understanding and a contact (Di Petta 2006b).

This *Erlebnis* of pain is intersubjectively understood in its singularity and pluri-vocality. It is breaking off from the background. Faces, hands, clothes, and gestures shape this pain. They sculpt it. The experience takes shape. The eidetic details coagulate in a meaningful experience.

The eidetic analysis of pain as a central experience (loss of freedom, loss of life, loss of contact with children and family, with their own world, etc.) experienced together by all, gives pain an access that is normally precluded to individuals, as they could not bear it on their own. The individual, open and circular pain, that is, an atmospherized pain, is then charged with value. In a life that is torn apart from its own world, suspended while awaiting judgement, and standing between now and not yet, pain represents a heart-felt bond, which is then firm, with their own history, and also conveys the meaning of a future. Pain such as that makes you feel you only exist as something or somebody who has been injured or is now sorrowful, that you have to bear in mind your own existence, at least the pieces that remain of it, and that you need to move forward. In a universe like prison, where the law of violence, control, and overpower prevails and self-harm is often the only way to get noticed, crying, embracing, and indulging with the vulnerable tenderness of emotions translates into at least getting free from the bars of the internal coarctation.

Can their encounters with the others and with themselves, in this dense, rarefied and authentic atmosphere, bring them hope again?

4. Being in the dream

“We are made of the stuff of dreams,
And thus dreams open their eyes
Like small children under the cherry trees,
From whose crown the pale golden course
Of the full moon lifts up through the great night.
[...]

And the three are One: a human, a thing and a dream.”
(Hugo von Hofmannsthal, *On the Transitory*, III, tr. S. Horton).

Another supporting example of the indissoluble crossing of the atmospheric with the eidetic is represented by the dream. In the dream, the ambivalence of the atmospheric and the eidetic is at its highest level. Images become well-defined and then blur; the flavour dreams leave with us upon awakening pertain to this dilution of the eidetic in the atmospheric. Sometimes, we ignore the whole content of the dream. We only feel its sense. That is, the eidetic condensate of its atmosphere. Sometimes, shapes deform and become atmospheric, thus dissolving into one another.

The dream, as explicitly defined by Foucault (1954) in his long introductory essay to *Dream and Existence* by Binswanger (1930), is a specific form of experience. Therefore, once freed from psychological reductionist assumptions, the dream is the form that takes life during the oneiric experience. Is it possible, then, to still perceive the existence precisely where it seems to blur and disperse, and without resorting necessarily to a metaphysics of the unconscious? Whereas Foucault finds in the dream a historical a priori, where freedom is realised and denied, and the transcendence of the imaginary unfolds, which is to be excluded—for history and reason to occur, Binswanger identifies an ontological a priori that unveils a particular way of man's being, that is being in the dream. While Freud (1900) connects dream to desire right from the beginning, by means of a dramatic personification of the dream, Binswanger puts the human ego in the face of its fall, namely its own pain, even with the inertia of the body. Binswanger sees the man of the dream as a presence that either rises or falls, and that does so totally unintentionally.

What is the a priori structure of the dreamy existence? Is the one revealing the pulse of presence, its systole and diastole, its expansion and depression, its rise and fall? In dreams, the images, which have a strong aesthetic impact, are nothing but condensates of rise and fall, the fixed points of sinusoidal waves. During dreams, it is clearly the human fragment rather than consciousness, that echoes with humanity. In other words, the universal intersubjective plot is revealed throughout the subjective vagueness. In this regard, the (eidetic) themes, that is, the forms of the dream, have a potentially atmospherizing charge. For instance, the awakening of the meaning of the infinite, that transforms the fall from a linear trajectory into a free and exhaled rise. According to Heidegger (2001), dreams of distress are the prototype of the primary existential angst concerning one's presence as such. The main ontological feature of any dream is its kinship with angst. From this point of view, Binswanger goes even deeper into the biological nature of the dream. Dreaming, man is "life function"; waking, he creates "life-history" (Binswanger 1970a). Both, however, have a common foundation, that is existence.

In the attempt to recover the oneiric meaning, the *Dasein* analyst must consider himself and the patient as two children in front of a shop window. We are in a foreign country, and the shop sign tells us nothing about what the store sells. The only indicator is the shop window. There, items must have been displayed by a hand, which is not only an expression of an individual will, but also executed by a “Man” (in German) that is a “Someone”. The item display in a shop window is not the answer to the simple bundling up of the same, just like an inventory stacking operation, but it is rather inspired by an evocative and suggestive picture, displaying the main items in a single window, thereby summarising the contents of the store. In this way, and along with the choice of some items, other objects are being placed but not put up for sale, as they are only used to create the scene and evoke a setting (old leather-bound books in wooden shelves, golf clubs with leather covers, pocket watches, eyeglasses, old skis in men’s clothing stores for half-sports, half-elegant style). The perfect showcase, indeed, should evoke an atmosphere, within which eidetic details related to the items being sold can be understood. Actually, the atmosphere refers to the life-world, while the items represent the “data” to the forms that populate it. There are many ways to decorate a showcase to attract the passers-by, but all of them have the common denominator of not being a random display. There must be no mess. In the essence of the elements, in a finite room, a proportionate relationship exists with the infinite, that is this atmosphere.

5. The twilight state

What do drug addicts mean when they say they are doped-up, distraught or high? What is the psycho-pathological equivalent for this state of consciousness, a kind of stand-by, steady state to them, that is, a condition of non-equilibrium, yet being sought after and experienced as essential? In some pioneering work by Callieri back in the 1950s, carried out with intoxicated subjects, the expression *twilight calm* was already in use. With these studies as our starting point, we have psychopathologically envisioned the trip experience as a twilight state of consciousness. The twilight state of consciousness (*Daemmerzustand* or *Daemmerungzustand*) was traditionally (Jaspers 1964, Mueller, Scharfetter 1982) intended as a condition where the field of consciousness of the subject is restricted, that is, constrained around a few or even a single content. The twilight state, without the anxiety or anguish element, should be—again—the state of consciousness of the sage, of the ascetic, or even of the psychopathologist

phenomenologically founded in the act of their clinical intuition or eidetic vision.

In a twilight state, there is no real reduction of vigilance, so much so that the subject is able to make oriented and finalised movements into space ("oriented" or lucid-consciousness twilight state). Moreover, the field of the twilight state of consciousness may again expand or widen in concurrence with or in the event of suddenly surging and alarming factors. The term twilight, as is evident, refers to a certain time of the day, namely, the transition between light and shadow. The twilight or, better, the light-and-dark state of consciousness may also be defined as a liminal consciousness or a threshold, border consciousness that stands between the light of reality and the shadow of psychosis.⁸

Therefore, the light-and-dark state of consciousness, otherwise defined as a twilight-auroral state, i.e. the trip, is a state per se that prompts a visionarity made of illusions and hallucinosis. By dissolving, the object is removed from the fixation, thus leaving a free background that becomes populated by something else: the hallucination. The lived experience of either allopsychic or autopsychic depersonalisation, or that of derealisation, are typical and reversible possibilities of the light-and-dark condition given by the trip, where nothing psychotic is found so far (Di Petta and Tittarelli 2016b).

6. *Wahnstimmung* and perplexity

Some structural key-elements were identified by Callieri in his well-known work *Wahnstimmung*⁹ of 1962:

⁸ The twilight state of consciousness, therefore, accounts for the peculiar acuity of the phenomenological gaze, able to trace the essential lines of a landscape, just as the latter is fading at sunset or is outlining at sunrise. It's like the vision you may have in a night landscape after it has been passed through the sidelight of a long and sudden lightning. Suggestion accompanies lighting, shadow thickening accompanies clarity of the contrasted surfaces. What is immediately clear is the outline of things. A series of other states of consciousness resolve in this, for instance, the dreamy state of some kinds of temporal epilepsy, or that state described by literature between 1800s and 1900s, and referred to not by chance by Gaston Bachelard (2008) regarding the poetics of *rêverie*.

⁹ In Callieri's work of 1962, for the first time and by an Italian psychopathologist, the *Wahnstimmung* (WS) has been studied as a mode of experience in itself, distinct from its necessary delirious evolution. Focusing on *Stimmung* means basically dealing with the delusional atmosphere as a lived experience in itself, and not just in view of the imminent and pressing delusion. It can be generalised that, in the history of psychiatry in this century, there has always been a retrospective

- 1) Suspension of meaningful completion;
- 2) Subjective hypertransfer;
- 3) Spreading the intention to mean;¹⁰
- 4) Dissolution of the transcendental formal symbolic contents.

In his famous work dated back to 1962, Callieri cleared the fog of *Wahnstimmung* by displaying an articulation skeleton that recognises the intentional device that goes hand in hand with its peculiar functioning. As a matter of fact, Callieri was able to deconstruct into precise eidetic details, the pre-delirious Stimmung cloud, which is the atmospheric by definition in psychopathology. Certainly, in the case of psychotic *Wahnstimmung*, we are faced with a transcendental apparatus functioning differently.

The atmosphere associated with such phenomenon can also be expressed in terms of *Wahn-Stimmung* or *climatique*, translated into “state d’animo” (mood) in Italian psychiatry. In the last few years I have dealt not only with the phenomenology of encounter, but also with the ecology of the encounter: atmospheric conditions, climate, and mood of the milieu representing the delusional relationship with the world. With the term ecology, I concretely mean *the air of the encounter* (Resnik 2005).

However, what role does the mood play in all this? The term Stimmung, as is well known, relates to a basic humourality that dyes the environment with its sinister tint. The environment is then left sinking, and has now little to do with consciousness.¹¹ Alternatively, should it be

look on WS, like a preparation field or a pre-stage of delusion, while Schneider, mentor of Callieri, states that “delusional perception is not inferable from mood. Such mood perceptions already have a meaning in several ways, but nothing determined yet. Due to such indefiniteness, it cannot provide from a thematic standpoint any directive for a further delusional perception”. He insists on the non-derivability of WS and on its character of unmotivated irruption (Di Petta 1999).

¹⁰ Muscatello, regarding Hofmannsthal: “it seems to us we have glimpsed an understandable transition, a real connecting link, between the experience of losing the natural evidence and the delusional ‘hypersignification’. The first part of the text closely reminds us of the moments of ‘losing the natural evidence’, of ‘crisis of meaning’ of Lord Chandos’s letter [...]. Such descriptions make us go back to the roots of that ‘perplexity’ preceding *Wahnstimmung*, to the root of ‘losing the natural evidence’” (Muscatello et al. 2003).

¹¹ In *Wahnstimmung*, delusional themes which, after all, have not shown yet do not matter as much as the atmosphere full of anticipation and mystery, pervading the world and echoed by the bizarre and unknown inquietude of the sick person. In

assumed that intentionality is not the prerogative of consciousness, but rather a directionality that can affect the senses, or even the entire engine of human sensory-motor apparatus? “A Moment of True Feeling” is the title of a novel by Peter Handke (1980) that describes a day in the main character’s life, pervaded by a delirious atmosphere. The revelatory element, which is still vague in the *Wahnstimmung*, witnesses the tension to the eidetic condensation of the climate of the epochal suspension, which in itself is difficult to tolerate in the pure suspicious state. Another point of intersection between atmospheric and eidetic is the delirious perception. Namely, the perception of something existing, whose meaning is learned as abnormal and often atmospheric, as referring to oneself, or to things that have to do with oneself. For instance, may the atmospheric and the eidetic concurrently occur in it? If perception already contains the form of the new meaning, there is obviously something eidetic, essential, obviously varied by common sense, and at the same time the delirious element is atmospheric, in the sense that it derives from an atmospheric tint that comes before it, and in turn tends to get the theme atmospheric.¹²

7. The horizon

In this respect, the concept of horizon of meaning meets us halfway. In the horizon, there is always something more and something less. Perhaps, the horizon is the area of discernment and confluence between the atmospheric and the eidetic. The notion of horizon can be considered as the point of convergence and divergence between the atmospheric and the eidetic. The form that ripples on the horizon line is the eidetic, whereas the

1982 Callieri named it “Good Friday Atmosphere”, summarising in a vivid image the descriptive clinical anecdotes and, at the same time, alluding to the deep sense of this experience without making it plain. Sense that Del Pistòia calls “sense of the sublime”.

¹² The so-called “oneiroid psychoses”, that Willy Mayer-Groß described in his monograph (Mayer-Groß 1924), have a slant similar to *Wahnstimmung*: the “atmosphere” effect. Cases of such kind were already known for a long time by psychiatry (Ey 1954) with a collocation ranging between confused delusions or dysthymia, depending on the affectivist or dementalist inclinations of the psychiatrist involved in describing each event. Mayer-Groß’s and Jaspers’s originality is to have found “les mots pour le dire” (the words to say it): they don’t come from a clinical discovery but from a methodological jump. Their point of view is no longer from a scientific observation, but from a phenomenological understanding; and the “atmosphere” effect can be described as an altered dimension of the “intentionary consciousness”, whose consciousness is not a “psychic function” but an “openness to the world” (Del Pistòia 1996).

diffusivity and pervasiveness of the horizon has to do with the atmospheric. In clinical experience, the semiology of the patient's phenomenal mask compares with the one of the interviewer, i.e. the therapist. What results from the encounter then dialectically translates into a dynamic comparison between two possible horizons: the one arising from the patient, and the one that emerges from the therapist. Everybody will do their own semiology. The patient also needs to know who is behind the other that formally embodies the interlocutor-therapist. On the other hand, the therapist must cautiously approach the visible and invisible reality of the other.

In the essay *Der sensitive Beziehungswahn* (1918), Kretschmer's minor work theorising the application of psychotherapy to delirious disorders "up to the border with schizophrenic psychoses", the author sets a milestone in the history of 20th century psychiatry. In its essence, the delirium of the sensitive shows a particularly obvious pattern in this path: the shame, the shaking of the image of the self, which increasingly falls prey to a radical process of mundification, where others report their contempt at first, and finally their being persecutory. If a shame-anger slip is an intrapsychic way of seeing, understanding the passage from the feeling of a shameful defection to one of persecution? The swinging between the self-shame and a coexistent shame sheds light on the possible formation of a different, delirious world.

Going back to the body theme, the persecutor has the semblance and features of an opaque body (Del Pistoia 2008), whose interior remains inaccessible, thus leaving the thoughts enclosed in it inaccessible. The opaque body of the persecutor acts as a transmitting station of delirious signals that are notoriously not only verbal but also mimic-gestural. The characteristic of signs is polysemy. Therefore, the eidetic of paranoia is the experience of the opaque body beyond its typical argumentation and hypochondria, in which, following our reasoning, the Atmos changes status and condenses or becomes a deposition from vapour, until it takes the form of Eidos with a seamless sublimation constant.

8. The situation

Those in the situation are hardly aware of it. Being located appears as something given, which narrows the space of subjectivity and will. Instead, those out of the situation can see the subject in the situation. Grasping the atmospheric returns the character of the event to the

situation. Not only does grasping eidetic details clarify the situation,¹³ it reduces the power of making the situation atmospheric, and reduces dispersion. The eidetic actually implies the atmospheric, drains from the atmospheric, which at the same time understands, intensifies its character, and reduces the exhilarating redundancy of the halo effect.¹⁴ In this sense, the eidetic discriminates while the atmospheric embraces. Being located also means being emotionally located. It means living in that region of being what Heidegger calls *Befindlichkeit*, which literally means befoundedness, that is, how I am located in the world.

Could it really be that a way of gazing, of being-with, a “simple” way a man encounters himself, with other men, in a room and through a unanimous *Stimmung*, represents a possible cure? Elsewhere, we have argued not only about its actual feasibility, but we also have enhanced and extolled its great transformative and therapeutic potential, so that phenomenology itself becomes a therapy or, in other words: sensing is understanding, and understanding is curing, genuinely meeting each other, existence to existence, is changing. Studies and considerations on “new”

¹³ If we keep following Calvi in his last work (2013) containing many of his contributions and *phenomenological exercises*—intersubjectivity has aesthetic grounds as it represents the body co-feeling, where the very act of feeling can be an *eidetic vision* or *mimesis*, in an intentional movement that embraces the voluntary and the involuntary, the conscious and the unconscious, in itself.

¹⁴ The halo represents the visionary essential. You need to think about something different, something metaphysical. That something can be imagined and described as a “halo” surrounding the *Leib*, the living body. Some people have a thin and transparent halo, penetrated by other people’s eyes. The halo can be imagined as an unreal covering; in fact, embarrassment is often described as an experience of nudity, as being undressed by eyes. It is worth underlying that the halo is unreal not in the sense that it is not real, but in the sense that its reality is different and can be found beyond physical reality. Opacity and transparency are expressing experiences of the further. When someone is said to be distant and unapproachable, it means that a thick, cold, opaque halo surrounds them. Instead, the halo of someone who is said to emanate pleasantness or sincerity or even sanctity must be soft and warm. For many centuries saints have been portrayed with an aureole, probably in an attempt to make their halo visible to everyone, a halo some people perceived, thanks to what we would call with Husserl’s terminology the “second sight” of eidetic vision. The halo is the image expressing someone’s relationality in terms of opacity and transparency. The halo image helps to introduce the understanding of a specific lived experience: the borders of the personal, lived body do not coincide with the anatomical entity of the objective body. Let’s now imagine the body is “penetrated” from the inside. It is as if we see an object through a transparent veil: if the opacity of the object increases, it becomes more and more visible until it seems the veil has disappeared (Calvi 2005).

psychotherapies, studies on communication, on genuineness, on mutual implication, on intimacy, go towards this direction, especially the Group Analysis of being there, a phenomenological group device, developed and “perfected” in the approach to the world of drug addictions, of “synthetic psychoses” (Di Petta and Tittarelli 2016a), and of borderline lives. In such a context, anguish, a “terrible disorientation of being”, this form of *Befindlichkeit* analysed by Heidegger (1970)—is revealed, lived, verbalised, rationalised, understood, eidetically grasped in its essence of an emotional phenomenon that makes you suffer, endured and felt by the vast majority of the Group, absorbed in a hanging atmosphere of derangement—in other words, aesthetically transfigured.

Unveiling the *atmos/eidos* of a situation means giving the situation the time pulse of the event, which, as such, is dynamic and involves overcoming the situation. The biggest danger for the subject is that the situation becomes stagnant. Stagnant either in the depressive, manic or obsessive situation. In pathological conditions, the situation prevails over the subject by throwing a curve ball in an overtime period, shifting from one situation to another. In clinical diagnosis, the meaning of atmosphere has been recognised for a long time. Tellenbach, indeed, believes that during their interaction with patients, physicians are lead to feel certain atmospheric qualities that go beyond the fact itself and the clinical situation, but that, however, permeate and indicate the diagnostic process. This has led him to develop the concept of *diagnostic atmosphere*, whereas Minkowski uses the term “diagnosis by penetration”, a similar term to refer to the importance of intuition (non-cognitive grasping of the meaning of an object) in the diagnosis process, with special reference to the diagnosis of schizophrenia. Diagnosis through Feelings (Binswanger 1970b); Diagnosis through Intuition (Wyrsh 1946); Diagnosis by Penetration (Minkowski 1998); Diagnostic Atmosphere (Tellenbach 2013); Knowing through relationship (Schneider 1925). These concepts prove the fact that all these authors recognised a sort of *atmospheric participation* in understanding phenomena. In arts, especially in performing art, atmospheres are present from the beginning and are essential for the overall understanding of the work: “the first scenes directly instil a certain emotion in us, directing all our understanding”. During the encounter with patients, the atmosphere into which clinicians are initially thrown also helps them learn the “quality of the world”, which will guide their understanding. (Costa et al., 2014; Rossi Monti 2008).

In this sense, phenomenological care is a cure for the situative, namely a work in which the clinician takes part in the patient’s situation, thus

introducing from time to time shared elements, which are deemed useful for the modification of the field.

By “situation” I mean that spatial and temporal unity in which the intensive (historical) dynamics catches extensive (synchronous) elements to reveal itself as a unity with a gravitational axis of its own. A situation is that integrated unity through which tangible asymmetries, summoning those who take part in them, exist. [...] I qualify as “situational” the therapy falling under the phenomenological school of thought that seems to best enable “psy” technicians to meet expectations of their patients suffering from contemporary disease (Benasayag, 2016).

9. Landscape and geography

There is a double contribution given to aesthetics by the phenomenology of feeling developed by Straus: “the articulation of music and dance” (Straus and Maldiney 2005), and “the establishment of landscape space”. By rooting the two arts inside the pathic dimension of the *Empfinden*, Straus actually exposes the deep structures that can be tracked in each artistic form as an original formation of the lived space, where aisthesis and kinesis are inextricably interconnected (Messori 2013). The perception or “gnosis” space—characterised by the subjective act of localising—is not an original space; it is typical of geography, not of landscape—which the pathic space is connected to: “the space of the world of sensation is [...] to that of world perception as landscape is to that of geography” (Straus and Maldiney 2005).

The space of a “pathic” type is structurally different, both from a sensitive and from a kinetic standpoint. It is essentially acoustic. The sound—when it is not a signal, i.e. when it cannot be related to its sound source—permeates and seizes us like something that suddenly, unexpectedly shows itself, and it radiates like something taking us by surprise. The landscape space thus becomes the space of the unexpected encounter (Messori 2013). Dwelling means nurturing atmospheres, Griffero states. Therefore and first of all, dwelling is the aesthesiological and pathic search for the right atmosphere in an interior: specifically because, due to its synesthesis (though quite variable) features, it is protective of domestic privacy, comfort, and warmth; but also because it is able, at the same time, to satisfy the social-expressive needs—potentially directed to the external world too—more simply an accurate copy of the live, sentient, percipient, and perceptible body of the dweller (Griffero 2016).

10. Discussion and conclusions

The aesthetic perception of clinical atmospheres and the understanding of the forms or of the suspended worlds does not represent the same act of aestheticisation as in other clinics (Callieri, Maldonato and Di Petta 1999). This phenomenological psychopathology has a great evocative power, in an aestheticising sense. It is a psychopathology that uses the aesthetic channels, refuses and, in a way repels the overriding naturalisms, empiricisms, pragmatisms, and reductionistic positivisms.

The intersubjectively lived clinical experience, and the aesthetic experience, have in embryo a common denominator, i.e. the pathicity. Even if an atmospheric element is not objectifiable in a Jasperian perspective—either at an explanatory level or with a descriptive-phenomenological sense—it is in any case qualifiable where it is perceived and suffered as a medium of intersubjectivity. One of the best explanations of the *aidagara* or interbeing is that man cannot be considered as a single individual, but as a relational being within a network of relationships where other actors are represented by all other men, by nature and the society to which they belong, and so is within the daily full-contact relationship taking place amongst humans (Frattolillo 2013).

Feeling cold is an intentional experience, but within this experience we are already outside of ourselves: what we do is observing our self-emerging within the cold itself [...] even the structure of this “going outside” well before emerging in “something” like the cold wind exists thanks to its arising within the self of others. This is not an intentional relationship, but *aidagara*: “interface”. The discovery of the self in the cold feeling is originally the *ki* interpreted as *aidagara* (Watsuji 2014).

There is probably a top-level atmospheric, so that anyone can immediately grasp some aspects of the current situation. Just as there is a top-level eidetic, which is made of details, so to speak, that anyone is able to grasp. All this overlaps with what common sense calls epidermic, intuitive, or perspicacious. Then, an ontological leap is needed for both dimensions, namely the atmospheric and the eidetic. That is, disengaging from the world of worldliness to meet the life-world. This is a transcendental dimension where both the atmosphere and the eidetic image meet some form of constitution or, in other words, that need to be constituted. This second level is accessible to phenomenological work, and is the only one that allows the work of refounding alterity and intersubjectivity. This appears to be evident in the situational crises of the clinic.

The first or survival level is ontic, accessible to all, characterised by psychological attitudes, which are not as much anthropological, that is, not deferred to the structure of the human being, as being in the world.

The first-level atmospheric also plays a depersonalising action, that is, prompts the *epoché*, and transports the subject out of the worldliness of origin. At this point, the prepared subject starts grasping details allowing them to structure the world where they are, and to remember the world they come from. If the atmosphere of an event has been particularly good, it will leave a mark in consciousness, just like a dream. So, the day after, there is a need to get in touch with whoever was there that night or at that time, and share “rashly” or “calmly” the memory of that event with another person. A successful event is an event that ensures intersubjectivity. It rediscovers the original relationship we have with the world and with others, a relationship that, once rediscovered, only enriches us, enables us to be reborn. Ultimately, we believe this is the cure.

References

- Bachelard, Gaston. 2008. *La poetica della rêverie*. Bari: Dedalo.
- Ballerini, Arnaldo. 2015. “Il tempo della tragedia. La categoria dell’irrimediabilità nell’esperienza melanconica.” In Tittarella Marco, *Il segno della melanconia. Melancolia generosa e creazione artistica*. Roma: Edizioni Universitarie Romane.
- Ballerini, Arnaldo and Di Petta Gilberto. 2015. *Oltre e di là dal mondo: l’essenza della schizofrenia. Fenomenologia e Psicopatologia*. Roma: Giovani Fioriti editore.
- Benasayag, Miguel. 2016. *Oltre le passioni tristi. Dalla solitudine contemporanea alla creazione condivisa*. Milano: Feltrinelli.
- Binswanger, Ludwig. 1930. *Sogno ed Esistenza*. Milano: SE.
- 1970a. “Funzione di vita e storia di vita interiore.” In *Per un’antropologia fenomenologica*. Milano: Feltrinelli.
- 1970b. “Quali compiti sono prospettati alla psichiatria dai progressi della psicologia più recenti?” In *Per un’antropologia fenomenologica*. Milano: Feltrinelli.
- Blankenburg, Wolfgang. 1998. *La perdita dell’evidenza naturale. Un contributo alla psicopatologia delle schizofrenie pauci-sintomatiche*. Milano: Raffaello Cortina Editore.
- Buber, Martin. 2014. “Io e tu.” In *Il principio dialogico e altri saggi* (1923). Milano: San Paolo.
- Buytendijk, Frederik Jacobus Johannes. 1964. *Algemene theorie der menselijke houding en beweging*. Utrecht: Het Spectrum.

- Callieri, Bruno. 1962. "Aspetti psicopatologico-clinici della 'Wahnstimmung'." In *Psychopathologie heute*, ed. by Heinrich Kranz, 72-80. Stuttgart: Thieme.
- 1982. *Quando l'ombra vince*. Roma: Città nuova.
- Callieri, Bruno, Maldonato Mauro and Di Petta Gilberto. 1999. *Lineamenti di psicopatologia fenomenologica*. Napoli: Guida.
- Calvi, Lorenzo. 2005. *Il tempo dell'altro significato. Esercizi fenomenologici di uno psichiatra*. Milano: Mimesis.
- 2013. *La coscienza paziente. Esercizi per una cura fenomenologica*. Roma: Giovanni Fioriti Editore.
- Costa, Cristina. et al. 2014. "Phenomenology of Atmospheres. The Felt Meanings of Clinical Encounters." *Journal of Psychopathology* 20: 351-357.
- Del Pistoia, Luciano. 1996. "Psicopatologia: realtà di un mito." *ATQUE. Materiali tra Filosofia e Psicoterapia* 13: 155-178.
- 2008. *Saggi fenomenologici. Psicopatologia, clinica, epistemologia*. Roma: Giovanni Fioriti Editore.
- Di Petta, Gilberto. 1999. *Il Mondo Sospeso, fenomenologia del presagio schizofrenico*. Roma: Edizioni Universitarie Romane.
- 2006a. *Gruppoanalisi dell'esserci: tossicomania e terapia delle emozioni condivise*. Milano: FrancoAngeli.
- 2006b. "Daseinanalyse e Gruppen-daseinanalyse. L'incontro, l'amore, la cura tra tossici, psicotici e lucidi." In *Esperienza della soggettività e trascendenza dell'altro. I margini di un'esplorazione fenomenologico-psichiatrica*, ed. by Stefano Besoli, 193-230. Macerata: Quodlibet.
- 2010. "Il vissuto del vuoto: tempo, vissuto, cambiamenti. Per una fenomenologia dell'epoché." In *Nel nulla esserci. Il vuoto, la psicosi, l'incontro*. Roma: Edizioni Universitarie Romane.
- Di Petta, Gilberto and Tittarelli Danilo, eds. 2016. *Le psicosi sintetiche. Il contributo della psicopatologia fenomenologica italiana alle psicosi indotte da sostanze*. Roma: Giovanni Fioriti Editore.
- 2016b. "La dipendenza normale e patologica." In *Psicopatologia delle dipendenze*, ed. by Paolo Girardi and Massimo di Giannantonio. Pisa: Pacini.
- Ey, Henri. 1954. "'Bouffées délirantes' et psychoses hallucinatoires aiguës." In *Etudes Psychiatriques*. Paris: Desclée de Brouwer.
- Esquirol, Jean-Etienne-Dominique. 1838. *Des maladies mentales considérées sous les rapports médical, hygiénique et médico-légal*. Paris: J.B. Baillière.
- Frattolillo, Oliviero. 2013. *Watsuji Tetsurō e l'etica dell'inter-essere: la costruzione di una relazionalità intersoggettiva*. Milano: Mimesis.

- Griesinger, Wilhelm. 1865. *Traité des maladies mentales*. Paris: Delahaye.
- Griffero, Tonino. 2013. *Quasi-cose. La realtà dei sentimenti*. Milano: Bruno Mondadori.
- 2016. *Il pensiero dei sensi. Atmosfere ed estetica patica*. Milano: Guerini & Associati.
- Handke, Peter. 1980. *L'ora del vero sentire*. Milano: Garzanti.
- Heidegger, Martin. 1970. *Essere e tempo*. Milano: Longanesi.
- 2001. *Che cos'è la metafisica?*. Milano: Adelphi.
- Husserl, Edmund. 1970. *Meditazioni cartesiane*. Milano: Bompiani.
- Kimura, Bin. 2005. *Scritti di Psicopatologia Fenomenologia*. Roma: Giovanni Fioriti Editore.
- Kretschmer, Ernst. 1918. *Der sensitive Beziehungswahn*. Berlin: Springer.
- Janzarik, Werner. 1959. *Dynamische Grundkonstellationen in endogenen Psychosen*. Berlin: Springer.
- Jaspers, Karl. 1964. *Psicopatologia generale*. Roma: Il Pensiero Scientifico.
- Mayer-Groß, Wilhelm. 1924. *Selbstschilderung der Verwirrtheit. Die oneiroide Erlebnisform*. Berlin: Springer.
- Masullo, Aldo. 2003. *Paticità e indifferenza*. Milano: Il melangolo.
- Mentzos, Stavros. 1967. *Mischzustände und mischbildhafte phasische Psychosen*. Stuttgart: Enke.
- Merleau-Ponty, Maurice. 1945. *Fenomenologia della percezione*. Milano: Il Saggiatore.
- Messori, Rita. 2013. "Attraverso il paesaggio. Naturalità del teatro e teatralità della natura." *Ricerche di S/Confine*, Dossier 1. www.ricerchedisconfine.info
- Minkowski, Eugène. 1936. *Vers une cosmologie. Fragments philosophiques*. Paris: Aubier-Montaigne.
- 1998. *La schizofrenia. Psicopatologia degli schizoidi e degli schizofrenici*. Torino: Einaudi.
- Muscatello, Clara et al. 2003. "L'ora del vero sentire. Dalla perdita dell'evidenza naturale alla rivelazione delirante." *Comprendre* 13: 121-133.
- Paduanello, Matteo. 2016. "Il sentire atmosferico in Fenomenologia e Psicopatologia." *Comprendre* 25-26: 279-301.
- Resnik, Salomon. 2005. "La visione del mondo nella schizofrenia." *Rivista internazionale di psicoterapia e istituzioni* 10.
- Rossi Monti, Mario. 2008. "Psicoanalisi e psicopatologia. Controtransfert e sentimento precoce di schizofrenia." *Comprendre* 16-17-18: 325-345.

- Rümke, Henricus Cornelius. 1990. "The Nuclear Symptom of Schizophrenia and the Praecox Feeling." *History of Psychiatry* 1: 331-341.
- Scharfetter, Christian. 1982. *Psicopatologia Generale*. Milano: Feltrinelli.
- Schneider, Kurt. 1925. "Wesen und Erfassung des Schizophrenen." *Zeitschrift für die gesamte Neurologie und Psychiatrie* 99: 542-551.
- Stanghellini, Giovanni. 2013. "Lo psichiatra come cittadino del mondo." In *Schizofrenia e malinconia. Implicazioni psicopatologiche e filosofiche*, ed. by Norbert Andersch and John Cutting. Roma: Giovanni Fioriti Editore.
- Stanghellini, Giovanni and Imbrescia Rita. 2010. "Il tatto come organo di senso che ci orienta nelle relazioni sociali. Da Gadamer a Derrida." *Comprendere* 21: 266-291.
- Stem, Daniel. 2010. *Forms of Vitality: Exploring Dynamic Experience in Psychology, the Arts, Psychotherapy, and Development*. Oxford: Oxford University Press.
- 2004. *Il momento presente. In psicoterapia e nella vita quotidiana*. Milano: Raffaello Cortina Editore.
- Straus, Erwin and Maldiney Henri. 2005. *L'estetico e l'estetica. Un dialogo nello spazio della fenomenologia*. Milano: Mimesis.
- Straus, Erwin. 1930. *Vom Sinn der Sinne*. Berlin: Springer.
- Tatossian, Arthur. 1979. *Phenomenologie des Psychoses*. Paris: Masson.
- Tellenbach, Hubertus. 2013. *L'aroma del mondo. Gusto, olfatto, atmosfere*. Milano: Christian Marinotti Edizioni.
- Tittarelli, Danilo. 2015. "L'esperienza estetica: risonanza emotiva e formule del pathos." In *Il segno della melanconia. Melanconia generosa e creazione artistica*, ed. by Marco Tittarelli. Roma: Edizioni Universitarie Romane.
- Vetrugno, Laerte et al. 2014. "Fenomenologia del patico e gruppoanalisi dell'esserci." *Comprendere* 24.
- Watsuji, Tetsuro. 2014. *Vento e terra. Uno studio dell'umano (1935)*. Milano: Mimesis.
- Weizsaecker von, Viktor. 1968. *Der Gestaltkreis. Theorie der Einheit von Wahrnehmen und Bewegen*. Stuttgart: Thieme.
- Wyrsh, Jacob. 1946. "Über die Intuition bei der Erkennung des Schizophrenen." *Schweizerische Medizinische Wochenschrift* 46: 1173-1176.

CHAPTER SEVEN

INTERVIEW WITH MIGUEL BENASAYAG

GIANNI FRANCESETTI

Gianni Francesetti: Dear Miguel, first of all, I would like to thank you for agreeing to contribute to this volume on atmospheres and psychopathology with this *entretien*. It is a topic addressed by great names in classical phenomenological psychopathology, such as Jaspers and Tellenbach, but since then this field of inquiry has virtually disappeared from the radar of debate in psychiatry and psychopathology. The aim of this volume, therefore, is to pick up the threads and, if possible, inject new life in this field of inquiry, one which, together with many other exploratory inquiries, moves towards an epistemological framework that embraces a contextual perspective, one able to go beyond the Cartesian dualism that separates inside from outside. In this sense, the title of the book, *Neither Inside, Nor Outside* is both telling and purposeful.

We thought of inviting you as one of the authors of the book because your approach builds considerably on contextual—and not just individual—factors in clinical work. Years ago, when I read your book *Les passions tristes* [Benasayag 2003], I realized that what you were describing was the affective tonality of an era, of our space-time, imbued with a sadness that comes from having lost the promise of the future, and seeing it as a threat. Now, an affectively-charged space-time is an atmosphere. Your perspective strikes me as interesting because, by shifting from the individual to the social, it opens up a discussion that goes beyond the confines of the clinical world and further helps us avoid individual reductionism in psychopathology. These were the considerations that led me to invite you to contribute to this book.

Miguel Benasayag: I identify with these premises and thank you for inviting me.

Gianni Francesetti: Well then, let's set off on this brief journey of ours, starting perhaps from your conception of psychopathology.

Miguel Benasayag: Sure. I would start with a topical example, from an issue that has emerged recently here in France, which poses a challenge for phenomenological psychiatry and existential psychotherapy. I am referring to the patently psychopathological approach that the government has chosen to take to terrorism, by asking psychiatrists, psychoanalysts, and psychotherapists to address the "psychopathological problem" of terrorists. The issue is a highly complex one. Orthodox Freudian and Lacanian psychoanalysts, for instance, believe a psychic "essence" or "structure" exists, so it could be possible to focus on what is specific to being a terrorist. Thus, it is possible, through psychological investigation, to predict who will become a terrorist. The same is true of psychiatrists who make use of nosographic systems, such as the DSM, to identify a typical terrorist "profile". In both cases, it is assumed that an *a priori* structure exists that leads a person to become a terrorist. In reality, the matter raises a number of problems. While we may be tempted to classify certain people "essentially" as candidates for becoming terrorists, and we certainly can find such tendencies in human beings, we cannot therefore conclude that a determinism exists prior to the act which allows us to predict a person's behaviour. Think of Sartre's famous slogan, "existence precedes essence": it is, in effect, from the concrete reality of a situation, with the infinite variants it implies, that an act emerges. We, as phenomenologists, have an important role to play in today's society—a society characterized by violence and radicalization fuelled by desperation—because our perspective permits us to focus on the emergence of a concrete situation without falling back on false assumptions of priority.

Gianni Francesetti: What you are touching on is a central point. Any kind of reductionism that ignores the abstraction it involves risks losing sight of what is happening. For instance, reducing the social and political aspects of terrorism to a psychopathological aspect is a reductionism that risks not understanding the phenomenon. I believe it is particularly difficult to live in a complex society like our own and the temptation to simplify things is always strong. Simplifying reduces anxiety and offers easy solutions—a rationale that in part may explain the growth of right-wing populism in Europe today.

It is not enough to study the individual to understand human phenomena, and treating terrorists as madmen will not suffice to

understand terrorism. It seems easy to just offload onto psychiatry—yet again in human history!—a sore that society wants to correct, segregate, exclude, or eliminate.

Miguel Benasayag: Absolutely.

Gianni Francesetti: So, you view psychopathology as a complex event that cannot be reduced to a single element, be it neurotransmitters, the individual, family history or society, but as something that encompasses all of this. And the risk you underscore, therefore, is that by asking psychiatrists to study terrorists and identify what is going wrong in their heads, any other consideration of a historical, political and social nature will be suspended.

Miguel Benasayag: Exactly. But what can we say from a phenomenological position? We are always extremely frightened by the horrors of war, but in reality—and this is where existence precedes essence—even for us, sitting peacefully here chatting in a Paris café, just one month of change in our condition (for instance, if we found ourselves in a situation of emergency or violence) would suffice to make us capable of killing somebody. We often ask ourselves rhetorical questions on the nature of human beings, on how it is possible for humans to commit torture, on how Auschwitz was possible, and so on, but they are all questions that relate to a pure idealization. The truth is that human beings exist in a complex coming-about that depends on the conditions in which they find themselves. For example, if we were to witness a killing right now, here on this street, we would be traumatized for life by it, but in a situation of war, the same episode would not have the same effect on us. It is important to remember that we are *not* the same people in different situations, and this non-‘*me-ness*’ is a mystery that has no answer. It is also a mystery that lies at the heart of Spinoza’s ethics, which establishes that we cannot know what a body can do. No matter how much we know about a person—or about ourselves—it will never be sufficient to predict behaviour in a different situation.

From this point of view, phenomenology shows courage—the courage to face the patient, the situation, history, without losing sight of its limit and “not knowing”. Sartre, who I was lucky enough to have known personally, used to say something which for me is very important: we always struggle with a certain degree of ignorance. We can even go so far as to put our own lives at risk, but always with a certain degree of ignorance. Phenomenological and Spinozan ethics build on “not knowing”

as an ignorance understood not in a negative sense, but as a not-knowing that gives us direction and warning.

Going back to the issue I started with, namely, the social role that psychiatrists and psychoanalysts have been called upon to play in the fight against terrorism, I think we need to help society endure the fear, without falling into the trap of presuming we can know who will become a terrorist, declaring and asserting instead the impossibility of knowing. At the same time, we need to try and understand that we live in an era of fear and desperation—that is the climate we live in, the atmosphere we breathe in this nihilistic society of ours. It is important to understand, which does not mean justifying.

Gianni Francesetti: As you have written, Big Data used to construct predictive profiles is adding a paranoid element to this atmosphere of ours of fear.

Miguel Benasayag: It certainly is!

Gianni Francesetti: Let me pick up the thread of your considerations for a moment to connect them to some of the themes of the book we are working on. It seems that you hold that we are subject to something that transcends us, i.e., to the condition we find ourselves in, which is an expression of the existentialist assumption that existence precedes essence. We all suffer something that goes beyond our intentionality, and suffering in the Greek is *pathos*, which gives us the root of passion, but also of pathology. That is to say, we all emerge from something that goes beyond what we can know and what we can choose. Choice comes later. In this regard, I cannot help but think of the Stanford Prison Experiment conducted by Zimbardo in the 1970s, where he created a role-playing game at the university and divided up his students, all healthy and normal kids, into two groups: “guards” and “prisoners”. Zimbardo had to suspend the experiment after just six days, well before it was planned to end, because something had turned the guards, all “good kids”, into terrible torturers. The conditions created a climate that had an unpredictable, unexpected, and devastating influence on the students’ behaviour. As clinical practitioners, we need to focus not only on the individual, but on what happens *between* individuals. But going a step further, perhaps we need to take into consideration the conditions in which subjects find themselves, as they are constituted by them in some way. It is not easy to be aware of the climate we find ourselves in—just like fish are not aware of the water they are constantly immersed in.

I would like to ask you, therefore, after *Les passions tristes*, which you published at the end of the 1990s, what are the qualities that you believe characterise our time, the atmosphere we live in today? What are the traits of today's age, from which we all emerge?

Miguel Benasayag: I believe we are experiencing the end of a cultural era, what Foucault called the Age of Man—as a species and as a community—where we thought of ourselves as the subject of history and had enormous faith in the decision-making capacity and free will of human beings.

Gianni Francesetti: Human beings as the “subject of”, whereas now we are beginning to see humans also as “subject to”.

Miguel Benasayag: Yes, exactly. I was talking to a friend a few days ago who, like me, was a left-wing militant in Argentina and who decided, about forty years ago now, to go and live in a kibbutz, and it made me think of how, aside from all the politically correct positions one may take, kibbutzim, much like hippy communes and kolchozes, are proof of the failure of modernity, in the sense that it has become patently clear how it is not possible for us to decide how to live through an act of free will or the enactment of a law, it is not possible to choose our social bond.

Gianni Francesetti: Does the social bond emerge from the situation?

Miguel Benasayag: Yes. The family can be criticized from many points of view, but it is constructed anthropologically without any explicit will. The idea that humanity can change the course of history by decision is over. Kant's appealing, but at the same time horrible, idea of a mature age of humanity, where rationality prevails, has proven an illusion. Indeed, the overestimation of rationality has hidden and strengthened irrationality.

The big challenge today is understanding how the irrational side of humanity can be recast and integrated into rationality. The irrationality in humans is a fact. We are irrational. How else can we understand sports fanaticism, the relationship between adults and cars, gambling, or even the lust for power or money? The challenge is how to construct a rationality that is not grounded in the crazy and dangerous idea of overcoming irrationality.

The other big challenge for our age is one entailed by the end of the organic unity of living organisms. Discoveries in molecular and synthetic biology, together with the growth of the digital, have led to a situation

today in biology in which no clear concept exists of what it is to be living. We live in a world swept by hybridization. I address these issues in my book, recently released in Italy, *Cerveau augmenté, l'homme diminué* [Benasayag 2016], a work on the hybridization of the brain and digital machines, the outcome of over twenty years of study.

In my opinion, these are the two elements characterizing our time. ● On the one hand, we have a change of paradigm for which reason alone—and the free will that follows from it—is no longer what determines humanity. This leads to a number of major ethical problems. How can I act if I can never predict the outcome of my acts? I have to act in the situation, within the situation, and for the situation, without truly knowing the consequences of my acts. ● On the other, we have the fracturing of the organic unity of the living being, which poses the problem of what life itself is. Suffice it to think of the entire sector of the trans-humanistic, or post-humanistic, sciences, which talk of life without limits defeating death, of augmented humanity, of transferring the brain to machines. As a researcher, I often work alongside colleagues engaged in artificial intelligence, yet I do not know anyone who is able to clearly explain the difference between algorithmic calculation and thought. In our society, we are no longer able to tell the difference between being with a friend and being with a robot programmed to be our friend. I talk about this issue in a book I am currently writing, which will be entitled *The Singularity of the Living Being* [Benasayag 2017], a work at the crossroads of biology and epistemology, in which I argue a position that goes completely against the grain today—namely that there is an irreducible singularity in living beings—running the risk of being marginalized from the scientific field as a vitalist and spiritualist.

The two main points for me, therefore, are, on the one hand, the challenge of rationality and, on the other, the fracturing of the unity of the living being and the hybridization of humanity and machines. These developments are driving major changes that have repercussions also on the madness of violence. Too much loss of meaning can provoke a desire to take action as a redress.

Gianni Francesetti: So, an era in which rationality has pushed to the margins irrationality, which has burst back powerfully and unexpectedly. And an era in which the distinction between life and machine is being lost, where the limit has been overstepped and life has become numerical and technical, instead of existential and ethical.

Turning to clinical practice, the pushing of all that is not rational “outside the field” has also entailed a psychic suffering which is, precisely,

not rational: I cannot rationally explain my states of mind or my symptoms. In a context in which limits and suffering have to be placed outside the field, and there is no search for meaning beyond the bounds of the rational, the result is thus a pill, or therapy to eliminate the symptom in ten sessions. Us clinical practitioners risk being complicit in an attitude that imbues our time, in which malaise is irrational and dysfunctional, something to be segregated and eliminated because wellness and happiness are what should be normal. But we cannot just think that our task is to cut out suffering. We need other ideas. This leads us to a central question: do pain and human suffering have meaning, or not? If suffering is meaningless, then it can just be eliminated, as we are seeing with the experimentation of molecules that eliminate the memory of trauma. If, instead, it is meaningful, then it bears something with it, it bears meaning. After all, “to suffer” derives from the Latin *ferre*, which means “to bear”.

Miguel Benasayag: I believe the question of meaning is a fundamental one. There is something specular between radical terrorism and the rationalist West: ultimately, both show a contempt for life. At a biology convention today, everybody would laugh at the claim that there is a singularity, a uniqueness, in living beings. The dominant belief today (represented not just by the scientific mainstream, but also by the multinationals of Silicon Valley) holds that life has no specific laws and there are no limits that cannot be overcome by living beings. And then we are scandalized when a terrorist shows no respect for life by setting off a bomb in a public place. It is paradoxical!

Gianni Francesetti: Because obviously, and quite rightly, we are horrified by the terrorist, but then we lack the critical capacity to see that we ourselves circulate the same contempt for life in various ways. Are we so absorbed by our contempt for life that we do not realize it?

Miguel Benasayag: I believe we are. We need to become aware of this specular aspect, which is perverse in its nature. We live in an age in which we do not admit the existence of frontiers and limits, an age that lacks structural foundations, in which everything must be possible. But to say that everything is possible means giving ourselves up to psychosis, because if everything is possible then nothing is real. The real is grounded in limits. And this brings us to the point you raised about meaning. If everything is possible then nothing is meaningful, which leaves us with absolute nihilism. Earlier I mentioned our orthodox psychoanalyst colleagues: for them, meaning exists before the situation, because

something can be meaningful in relation to structure, to the history of each person. That is why, for them, nothing can be incomprehensible; everything is evident, nothing is random. But that, in reality, is the elimination of meaning!

Gianni Francesetti: To what extent does that follow a deterministic logic? Is it a cause-effect relationship, or does it tend to something like meaning?

Miguel Benasayag: It is a one-way, linear cause-effect relationship, which can be complicated, but not complex. Complexity is something else, which precludes linearity.

Gianni Francesetti: Because there is no predetermination or predictability in complexity.

Miguel Benasayag: Exactly. So, on the one hand, we have orthodox psychoanalysts who smother meaning with an excess of meaning and, on the other, neuroscientists who say it is all a matter of neurotransmitters: whether we are happy or not, depressed or not, it is all a matter of neurotransmitters. There are even some recent studies that examine how intestinal flora influence thought—all of which is very interesting and should not be underestimated at all, but it needs to be considered as an additional variable in the complex of factors that constitute a situation, and not seen as a linear cause-effect relationship which smothers meaning.

So, on the one hand, we have an absence of meaning in the technologies, and on the other, an excess of meaning (and hence meaninglessness) in orthodox psychoanalysis. Once again, however, phenomenology has something to say about our age—not only for psychotherapy, but in general: it is a vision of the world that enables us to have a non-dogmatic, but experiential basis from which to act. That means there is no meaning outside the singular situation. The only meaning is that which emerges in the situation. And, contrary to what one might think, that does not lead to cultural relativism, which is founded on the recognition of a multiplicity of different transcendental foundations. We presuppose neither the existence of a single, abstract universal foundation, valid for all, nor the existence of a multiplicity of foundations. Cultural relativism is really just the same as abstract universalism, all it does is multiply the foundations.

To give you an example: a young colleague who works with migrants asked me how to approach the problem of female infibulation. She said

that for us the practice is unacceptable, and it is, but our rejection of it cannot be expressed in colonialist form (as we know, pursuing the good of the people despite the people takes us back to experiences—such as Stalinism—that we have known and do not want to repeat). At the same time, however, neither can we say that everything is okay in the name of a certain culture and that, as it is legitimate in their culture, infibulation is an acceptable practice. Neither cultural relativism, nor universalism: the phenomenological approach takes into consideration that *this* girl who is about to undergo infibulation lives in Italy, that *I* am the practitioner seeing her, and so I have to find a way to act in *this* concrete situation. It is only from a phenomenological, situational approach that the possibility will emerge to create a new social bond, arising in the here and now, to produce a line of thought suitable for these conditions and avoid barbarity.

Gianni Francesetti: The possibility for therapy, therefore, emerges from the singularity of the situation. Otherwise, even with the best intentions, we risk, as I said before, circulating in different ways the very same issues we would rather eliminate.

Another paradoxical example of this circulation of the dysfunctions we want to remedy is evidence-based protocols. Public health ministers are clearly well-intentioned when they require psychiatrists to apply the best clinical practice—who would claim they are not? Except that their good clinical practice guidelines are *evidence-based* protocols with procedures developed within a medical context that are then applied in a field—psychiatry—that does not fall within the epistemological framework of neurology. According to those guidelines, for instance, any patient suffering from panic attacks has to be prescribed drug therapy, otherwise the psychiatrist will be liable by law, even if in the specific situation the patient may have no need for drug therapy or it may even be counterproductive. Here we see an instance of how singularity is lost.

Another aspect I would like to pick up on is that of how if everything is possible, then nothing is possible. An element you mention is the sense of helplessness. On the one hand, I feel helpless about what is happening, but on the other, all it takes is a smartphone for me to link up in an instant with anyone, anywhere in the world, read your biography, etc., in the sense that everything is within our grasp. It seems, perhaps, that a characteristic of our time is precisely this swinging between a sense of “everything is within our grasp” and “nothing is within our grasp”, which is precisely the situation in manic-depression. With depression, everything is meaningless because I cannot do anything about it, whereas with mania, everything is meaningful because I can do anything (but then, if

everything is meaningful, nothing is). I would like to ask you what you think about that. Have we moved from an age of sad passions to a bipolar age? Just as an aside, it is worth mentioning that bipolar spectrum disorders are increasingly being diagnosed all around the world.

Miguel Benasayag: Yes, it is true, the experience of our contemporaries appears to be one of being inundated with messages of omnipotence (we can do anything, everything is possible), while being in a state of absolute helplessness (nothing is possible). The dominant techno-scientific belief that there are no limits comes precisely with this feeling of helplessness and fear—fear of breathing polluted air, of drinking, of eating, of terrorism, of economic default, of populism. I believe fear is a fundamental issue from a clinical and social point of view. Clinical practice needs to take up the challenge of addressing fear, without making leaps forward that deny it. To explain that challenge, let me use an image that might appear a bit naive, the image of little birds in a nest. The nest is totally fragile and can easily be swept away by the wind—it is the image of fragility itself—yet for the little birds inside it, it is solid and safe. And it usually is sufficiently stable for the time they need to hatch, grow, and build up enough strength to fly.

I think this image is a useful one for today's world. We need to realize that we are not in the middle of a raging storm without any sort of shelter, but also that no absolute, invincible shelter exists. We need to learn to think about and live with this fragility of ours—a fragility connected with Spinoza's idea of eternity, which is possible because it is what exists in the here and now when we reach a sufficient level of existential intensity.

Gianni Francesetti: Absolute safety is an illusion, but it is a good system for selling products and policies that promise greater safety and greater well-being. The illusion of safety and happiness leaves us unprepared to face uncertainty and suffering.

Miguel Benasayag: Yes. It is clear by now that a certain idea of stable world peace is an illusion. We need to learn to live with this sense of precariousness, of cyclicity, of alternating moments of light and dark. At the same time, we need to learn that we are part of the flow of life, that life flows through us, but it is bigger than us. In my opinion, therapy needs to treat fragility not as something to be eliminated, but as a constituent part of life. When I was in prison in Argentina, a cell-mate of mine almost lost his mind from fear—the fear of the torture, the isolation, the screams, and so on. It was there that I understood that being in the same boat does not

mean being in the same situation: my cell-mate and I were in the same boat, but he was sliding into psychosis, whereas I was still able to think, to use my imagination, to take care of another person. Any clinical model that ignores the situation the patient finds himself in, and objectifies him by doing so, is anti-ethical.

For me, this is the message of phenomenology today: we are all in the same boat, but we are not all in the same situation, and so we have a responsibility, the responsibility to build something.

Gianni Francesetti: What you are saying helps us move on from the idea of eliminating something—suffering, fear, uncertainty, the lack of limits—to the idea of living with that something. We cannot avoid the storms, but we can build a nest. The image of the nest reminds me of another concept you talk about in *Les passions tristes*, which is the clinical understanding of bonds, because a nest stays in place because it is held up by lots of interconnected bonds. We can only start from what there is, which is the situation and the bonds we have. We cannot start from dogmas or ideals. Perhaps that is what roots us enough to be able to breathe. And perhaps it can give us some pointers on clinical practice, on how to work with patients.

Do you think such a position is an integral part of our culture and clinical practice, or is it an expression of what you call “resistance”?

Miguel Benasayag: Unfortunately, I do not think it is a commonly held position, because psychiatrists and psychoanalysts live in the same world as everyone else and they, too, suffer from the same illness as our society. Nevertheless, it is a position that in my view should be supported and developed as a form of creative resistance.

Going back to suffering and its meaning, I think there is, first and foremost, an existential suffering that concerns the fact of existing and not being able to know the meaning of existence, the foundations and the purposes of living. Such suffering is fundamental for the existence of bonds, of culture, and of society, and it has to do with the bigger questions of humankind and the limits of existence. Yet, today it is as though it has no right to belong to us, it is not acknowledged, and those who suffer are considered losers, dissidents almost, and so the tendency is to hide that suffering.

Then again, even physical suffering today is misunderstood. Medicine looks for the organic mechanisms of a pathology, but identifying the mechanisms is not the same as finding the meaning of the illness: every pathology occurs in the here and now of a concrete situation. The medical

treatments available to us are highly effective, but we forget that every pathology occurs in a real life, in a specific time and space. This connects with what you were saying just before about the importance of bonds. I do not have a bond, I am a knot in the bond. A knot that changes continuously, because it is impossible to think of an individual as always one and the same, and so to think of and understand ourselves means understanding as much as we can the bonds that constitute us.

Gianni Francesetti: It seems we have touched on all the points I wanted to discuss with you, because these last observations of yours touch on clinical aspects and show how a clinical understanding of the situation can only emerge from the situation and the bonds it implies, it cannot assume anything *a priori*.

But I do not believe that means that us clinical practitioners should approach the situation guilelessly, so I would like to ask you your thoughts on the training of practitioners.

Miguel Benasayag: I think a certain contempt exists today for knowledge and training, a falsely democratic idea that anyone can do anything. On the contrary, I believe that to take up the situation, we have to study extensively and that clinical practitioners should be trained in medicine, psychology, philosophy, anthropology... their training, that is, needs to be wide-ranging and in-depth. Today we see lots of new psychotherapy schools popping up and proposing new theories that are more or less unlikely, but instead I think that to reach the point of not-knowing, one has to navigate a great load of knowledge. It makes me think of an anecdote about Binswanger. One day, while doing his round of visits, he encountered a patient with major breathing problems. Binswanger took him by the throat as though to strangle him, and everyone there, although they did not dare say a word, panicked when they saw the patient turning blue! A moment later, though, he let go and the patient began breathing normally. Binswanger did what he did on the basis of his extensive medical knowledge and on an intuition—he obviously took a risk, but he did it because he could draw on his huge baggage of knowledge. Today we seem to think that anyone can replicate any behaviour if trained technically, or by relying on pure intuition, but that entails very serious risks. To reach the position of not-knowing that we spoke of earlier, we have to have assimilated a truly solid basis of knowledge and in-depth clinical and existential training.

Gianni Francesetti: ●ne of the risks today is reducing psychotherapy to a set of reproducible techniques, whereas what you are talking about is what Aristotle called *phronesis*, which—in contrast with *techne*, which is the mere reproduction of skills, such as making a vase—consists of knowing how to orient oneself by the wisdom of the situation. To arrive at that and manage to orient oneself by not-knowing, one has to know a whole lot.

Miguel Benasayag: Absolutely.

Gianni Francesetti: In this regard, though, perhaps what is lacking is a movement of people (psychiatrists, psychotherapists, psychoanalysts) willing to make a public stance in support of a certain idea of psychotherapy. I do not believe a manifesto for a certain perspective on psychotherapy exists. A manifesto that would be across-the-board, as such, as it would not belong to any one “school”, or any one field, but would unite all those people who believe therapy should not be reduced to a technique.

Miguel Benasayag: Yes, I believe that really is necessary.

Gianni Francesetti: I wonder what we could call such a manifesto... perhaps a “manifesto for a psychotherapy of the situation”?

Miguel Benasayag: I think it should include the three concepts of therapy, suffering, and era. It should evoke the meaning of the age and the question of the meaning of suffering. It should stand in contrast to the new religious promise of the techno-sciences, the promise that science and technology can cure everything, that we can defeat death, etc.—but without rejecting techno-scientific research, of course.

Gianni Francesetti: ●f course, but also without losing sight of the singularity of the situation, of existence, of limits.

Your continuous stress on not considering the individual in the abstract, your continuous emphasis on the situation and the limits it implies and from which real and concrete possibilities emerge, is very much in line with the research we propose in this volume: the possibility of steering psychopathology from the generally assumed conception of it as the psychic suffering of the individual to a broader field, a radically relational, but also social and political field. ●ne of your founding concepts is that of the situation, just as it is for Gestalt Therapy. And the

phenomenal field, in my understanding of it, is the ecstasy, the coming out of the situation in the here and now of experience. A field we perceive as an atmosphere. It is fundamental, therefore, to go back and start from the situation, in our time and age so unrestrained by spatial and temporal limits, and by limits in general.

Miguel Benasayag: Yes, I believe that incessantly returning to the concept of situation is illuminating today and we can do that also by trying to understand the climate—the atmosphere, as you put it—of our time.

Gianni Francesetti: Dear Miguel, I think we have come to the end of conversation now. Thank you very much for accepting to speak to me today, for your contribution, and for the lovely time we have spent here in this Parisian café.

Miguel Benasayag: Let me thank you, also for the profound sense of attunement I have felt in this meeting of ours.

Paris, 4 September, 2017

References

- Benasayag, Miguel. 2003. *Les passions tristes. Souffrance psychique et crise sociale*. Paris: Editions La Découverte.
- 2016. *Cerveau augmenté, homme diminué*. Paris: Editions La Découverte.
- 2017. *La singularité du vivant*. Paris: Editions Le Pommier.

AFTERWORD

NEITHER FROM THE “INSIDE” LOOKING “OUT” NOR FROM THE “OUTSIDE” LOOKING “IN”

DAN BLOOM

Things speak for themselves. This volume speaks. It demonstrates that “atmospheres” has crossed-over from the “new phenomenology”¹ to various clinical disciplines—psychology, psychiatry and psychotherapy. It and other ideas from the new phenomenology are now in Gestalt therapy as evidenced by this volume’s chapters by Francesetti and Roubal. In this afterword, I will reflect on this crossing-over and consider on what basis Gestalt therapy could be hospitable to some of the ideas of the new phenomenology. I will frame this within my own contemporary relational understanding of Gestalt therapy’s core concepts. Consequently, while I am looking “out” from “inside” Gestalt therapy, I assume my comments are equally relevant to modalities “outside” Gestalt therapy. The boundaries that separate modalities that have significantly similar worldviews are permeable, despite differences. There is neither an “outside” nor an “inside” in the sphere in which we work.

Those of us who hold the theory and practice of Gestalt therapy lightly rather than as dogma, can look at Gestalt therapy from other perspectives in order to see new possibilities or potentialities within Gestalt therapy itself. However, to look at Gestalt therapy from another perspective is not the same as adopting the other perspective. Neuroscience, for example, has *added* to our understanding of Gestalt therapy without itself *being added to* Gestalt therapy. I am not among those who have included the new phenomenology into Gestalt therapy, although as might become clear, just as adjacent tuning forks of the same pitch resonate when one is struck, ideas written about by others resonate with me. ● Our ideas resonate while

¹ Several authors also reference the usage of “atmospheres” by such people as Karl Jaspers, Ludwig Binswanger and Hubertus Tellenbach (see Francesetti, Fuchs, and Di Petta and Tittarelli, as well as the “Introduction”, in this volume).

maintaining separate identities. Since Gestalt therapy already profoundly resonates with philosophical phenomenology, it is not surprising that it also resonates with some aspects of the new phenomenology. This afterword is not the place for me to dig deeply into the varieties of these resonances.

1. Gestalt therapy as a clinical phenomenology

It is important to underscore and reiterate Gestalt therapy’s own phenomenology, which I believe has always already been intrinsic in it. Seen from one point of view among many, the phenomenological stance is the consequence of knowing that human *beings* are ever within a certain obscuring haze: my fingers touch the keys of this computer, yet in their touching my touching fingers and the touched keys disappear into that haze. I am alive in this “seen” world; yet this world that I perceive is also as invisible to me as water is to a fish. No matter how clearly I hear or how sharply I see, there is always more (and less) at the further side of my experiential horizon. Thence came Husserl’s directive, *Zu der Sache selbst*. And came Heidegger’s simple description of phenomena as “that which show themselves as themselves”, which focused phenomenology in its purest so it could do no less than lift that haze, and uncover, disclose, un-conceal what is always already there and affecting us - that which is always already in the air we breathe, on the ground we walk, and at the horizon we sight. To the extent Gestalt therapy is a venture of discovery, of bringing into awareness that which had been hidden, of finding clarity’s relief through the haze of personal suffering, Gestalt therapy takes a phenomenological stance. Or more to the point, Gestalt therapy is a clinical phenomenology concerned with the hidden and uncovered, the hazy and the clear.

2. “Experience occurs at the boundary of the organism and its environment”

Gestalt therapy began to sketch out its phenomenological approach in the very beginning of the theory section of its initial text, *Gestalt Therapy*, by Fritz Perls, Ralph Hefferline and Paul Goodman (1951) (hereinafter referred to as PHG). It begins, “experience occurs at the boundary of the organism and its environment” (227) Gestalt therapy will be concerned with experience and indeed, the structure of experience² itself. To some of

² The first chapter’s title is “The Structure of Growth”.

us contemporary Gestalt therapists, the original theory's frame directing us to this structure of experience is elegant in its simplicity. It is frankly phenomenological. This *phenomenological* Gestalt therapy approach facilitates our ability to sharpen our experience of a world *that is* our concern and further the as-structure or the "how" of this concern. This world is originally referred to as the *organism/environment field* with the locus of experience placed at the *contact-boundary*. As will become clear, these are important resonance points with "atmospheres".

Contacting is the process of experiencing and most significantly, the structure and process of Gestalt or figure forming. The "how" of experiencing this process as a temporal *sequence of contacting* is *self functioning*.³ These concepts guide the theory and practice of Gestalt therapy by allowing us to push the horizons of our *clinical* epistemology. At the same time they are the *practical* clinical tools⁴ for Gestalt therapy's process of disclosing what may be hidden in a haze of unawareness. These basic concepts introduced by Gestalt therapy are open windows to phenomenology, classical, contemporary and new. It is useful to keep in mind the introduction to this volume and some of its chapters (such as, Griffiero, di Petta and Tittarelli, Francesetti, and Fuchs).

In Gestalt therapy's clinical approach, the more such structures of experience become clear in the process of contacting, the more the fixed, hidden, and repeating gestalts are brought into awareness. A person's suffering is diminished as the contacting process becomes more and more free of the fixed forms that constricted it. Put in more formal phenomenological terms, Gestalt therapy accomplishes this with our version⁵ of Husserl's phenomenological method (Husserl 1931)—a *Gestalt epoché*, *reduction*, and *Gestalt attitude* as a particular way of looking at experience in terms of contacting (Bloom in press). Gestalt therapy achieves this attitude by employing its own *phenomenological reduction*, which identifies and sets aside the taken-for-granted presumptions of

³ This simple frame is not simplistic; there are more complex aspects that sharpen our approach into a clinical epistemology not relevant to this discussion. Because of its simplicity, the template allowed us Gestalt therapists to add, subtract, and reorganize this structure. I am avoiding any discussion of the various models of Gestalt therapy. Yet, Gestalt therapy never strayed from its founding phenomenological epistemology "experience occurs at the boundary between the organism and the environment."

⁴ As phenomenological as Gestalt therapy is, it never fails to be close to its roots in pragmatism.

⁵ There is no evidence that Fritz Perls actually drew on Husserl. There is no evidence that he didn't. This would only matter if my approach were strictly historical.

unexamined daily life (“natural attitude”), yet includes them so they can be experienced differently within the therapy relationship.⁶ The Gestalt attitude opens the patient and therapist to the experiential ground that is the basis for which the insights of therapy can occur, where the figure/ground process of contacting may be experienced in a whole, embodied, worlded, manner. Contacting itself emerges with its sensed, felt, and known aesthetic qualities (for example, Bloom 2003; Francesetti, Gecele, and Roubal 2013; Spagnuolo Lobb 2018).

3. Gestalt therapy attitude as an opening to the phenomenal space and time of therapy

As in post-Cartesian phenomenologies,⁷ Gestalt therapy lives and breathes in non-spatial spatiality, moves in non-chronological temporality, and embraces the whole of biological and lived-body. In the Gestalt attitude, the office is no longer a Cartesian box, the therapy hour no longer occurs in time ticked-off in minutes by the hands of in measured minutes. This now-and-here, this-now-and-here-*with-the-therapist*, is the situation of therapy set off from the ordinary or mundane and which now has its own kind of sounds and light and senses, its own intentionalities—its own aesthetic of contacting, an aesthetic of an embodied phenomenal whole. Our world of Gestalt forming is not simply concerned with the emerging forms (Gestalten) of experience, but with the forms and the formless, the subject and pre-subject as well in a phenomenal process of emerging poly-directional intentionalities⁸ (Bloom 2019). Contacting is a function of phenomenal space, which is an inter-personal, poly-personal, populated world. This space is the locus of the therapeutic relationship as the milieu of “therapeutic contacting.” This location is the *contact-boundary* (PHG 227).

⁶ Compare this to Di Petta and Tittarelli’s discussion of atmospheres and eidos.

⁷ Husserl (for the most part), Heidegger, and Merleau-Ponty certainly established this for all time. Heidegger famously leapt back to the pre-Socratic to re-establish his own model.

⁸ From its very beginnings and throughout its development, Gestalt therapy has offered fertile territory for concepts of the old, contemporary phenomenology, and now the new, to take root whether or not these concepts are actually necessary. Intentionality and more contemporary phenomenological concepts such as the aesthetic, pathic, pre-egoistic processes of awareness and consciousness are also part of contemporary Gestalt therapy (Alvim forthcoming; Bloom 2019; Crocker 2009; Bloom 2010; Francesetti 2015; Spagnuolo Lobb 2018).

4. The contact-boundary

Psychology studies the operation of the contact-boundary in the organism-environment field, [but] the contact-boundary, where experience occurs, does not separate the organism and its environment; [...] it is where experience occurs (PHG, 119, emphasis in original).

We lift our arm and hold it in front of our face. We see it as an object just as any object in the “environment”. We move our arm and feel it moving through space. This is a contact-boundary experience—the meeting of us as “object” of the environment and us as a human sensing “subject”—of a biological-material body and a lived-body.

As clinicians, we practice simultaneously at these two “levels” of the contact-boundary. Our work engages the entwining of two human “domains”. One level is the material world and the biological body; the other is the experienced world and the lived-body. One level is the level of clock-time and measured space; the other level is phenomenal temporality and immeasurable space or spatiality. It is on that second level that we find the world of shapeless, unformed phenomena, pre-predicative experience of a spatiality without dimension, qualities without names, feelings-not-yet-felt, vibrations-not-yet sounds, a saying not yet said, a temporality outside of time, a place without location—a neither here-nor-there, a neither-there-nor-then.⁹ Perhaps, it is a world of existence without existent. This entwining is ripe with potentialities of contacting. As the contact-boundary, it is the living place of the emergence of the figure/ground process of human personhood.¹⁰

5. Environment and lifeworld

Given this phenomenological description of the contact-boundary, is it sufficient to refer to it only as a function of the organism/environment field? It is not a mistake to do so since it usefully underscores the ecological situation of human organisms. Its limitation, though, is its naturalistic perspective or “attitude” (Husserl 1970). To the extent that we clinicians work within a humanistic, existential, and phenomenological rather than a material perspective, there must be a more accurate

⁹ See Di Petta and Tittarelli’s chapter in this book for a parallel consideration of this.

¹⁰ I hope so much of this resonates with “atmospheres” as used in the chapters of this book that noting them would have been superfluous. I have located this in Gestalt therapy before the new-phenomenology appeared on my horizon.

description. Psychotherapy sits astride the *Geisteswissenschaften* and *Naturwissenschaften* divide. In his criticism of the scientific attitude's limitation, Husserl proposed the "personalistic attitude", which is a more fundamentally human way of looking at the totality of life (Husserl 1970). The personalistic attitude as the Gestalt attitude offers an approach that underscores Gestalt therapy as a clinical phenomenology. This attitude suggests a solution to the implied naturalism of "environment": the contact-boundary as the meeting of the *organism/environment-lifeworld*¹¹ field.

Although not original to him, Husserl developed the lifeworld in different ways through his writings. It remains a slippery concept. Husserl referred to the lifeworld as the totality of our subjective world and the all-encompassing we-world, stretching backwards in time in our shared culture and history, laterally in our societies, and forward in our experiences of the future. It is the horizon of all horizons. Lifeworld also includes the natural world. Aron Gurwitsch writes that it is "the universal scene of our life. The soil, so to speak, upon which all human activities, productions and creations take place, the world of common experience, [...] our cultural world." (Gurwitsch 1970, 35, 52). It is the all upon which life depends and which structures our sociality, subjectivity, and intersubjectivity (Steinbock 1995). Erwin Straus adds another dimension to it: "The understanding of human expressive phenomena is rooted in an *immediate fundamental communality preceding every knowledge and irreducible to it*" (Straus 2000, 236, emphasis added).

The addition of lifeworld to environment converts the possibly naturalistic attitude of Gestalt therapy into a personalistic and phenomenological attitude, lenses whose apertures are wide enough to view the broadest horizon of human living. The lifeworld is the warp through which the woof of the therapy process is threaded in one indivisible process.

6. From environment-lifeworld to contacting and self

Contacting, then, is emergent of the contact-boundary of this organism-environment-lifeworld field. This field is the always already founding basis for this developing process. The *pre-given liminal*¹² lifeworld is the

¹¹ "World" in the sense that Husserl often used the term and, in the sense, that Heidegger developed at length is an alternative. I choose life-world because of its usage by contemporary philosophers. "Lifeworld" is significantly different from Kurt Lewin's "lifespace".

¹² It is liminal in the sense that it includes the pathic pre-experienceable ground.

ground taken up and gathered into meaningful wholes (gestalts)—the forms and contours of lived experience in the sequence of contacting. Actually, contacting *precedes* any organization of experience. In its first actuality, it includes “*inchoate* needs connecting the organism/environment, *undifferentiated, unfocused, diffuse uncategorized*, which is a direct sense of self’s co-emergence of the contact-boundary” (PHG, 378, emphasis added). Further, “[...] it is in and through contact that the psyche will exist and preside over future experiences. The *pre-* is both genesis and structure” (Robine 2014, 129, emphasis added). Consequently, the *pre-given* is the always already there complexities of the lifeworld, which are taken up as given to experience; it is pre- or fore-contact (PHG). ● Once again, resonance with various chapters of this book come across loud and clear.

Self, the temporal sequence of contacting, develops further as these givens become sharper, have form, agency, consciousness and identity. A shapeless presence becomes *this* shape. Things come into focus and have names. Sensations become colors. Urges become appetites. Immediate awareness becomes consciousness (Bloom forthcoming). There is felt and embodied, experiential content and an agentic conscious “I” capable of reflecting, of identifying, orienting, moving, choosing. And now comes a person who knows the world around him or her, experiences and knows his or her relational embeddedness in the world and can answer who he or she is, know what he or she has done, can plan a future, can gesture and be gestured to, have values and love and be loved. That is, be a person with the essential human capacity of *responsivity* to the other. “Atmospheres,” *eidos, pathos, atmos...* None of these terms would be foreign to this description.

Gestalt therapy accounts for this temporal sequence in terms of the activities of self functions—the id, ego, personality (PHG) and relational functions (Bloom 2013), discussed throughout Gestalt therapy literature. The relational function of self is the compass by which we are oriented toward the other with non-indifference and the basis for our “responsivity” (Waldenfels 2011), a fundamental condition of our location in the lifeworld. The relational function thus orients us towards or away from the other with whom we are finding our way amid clouds, mists, desires, fears, moods, and other opportunities, and constraints of the organism/environment-lifeworld. “Responding means more than intending or understanding” (Waldenfels 2003, 23).

7. Relational function: pathic subjectivity of responsivity: the undergoing of the other

Budding from the organism/environment-lifeworld field, then, self is rooted in a world intrinsically populated both diachronically in pre-given history and synchronically in a universe of social interactions. The relational function is the capacity *to see* the other as well as *be seen*. This accounts in Gestalt therapy terms for an “I” emergent of a “we” or a “we” emergent of an “I,” and of a “me.” Importantly it is through relational function activity that we differentiate the human other from the non-human other. The relational function accounts for our uncanny feeling when we are in the presence of a perfect virtual human avatar (see Fuchs in this volume). Against all evidence of sight and sound, we know “in our bones” it is not human.

Consequently, the relational function is our capacity to orient toward the qualities of human otherness that show themselves at the contact-boundary of a clinical situation, whose “atmosphere” cannot be overlooked because it is as powerful as a summer sun on our face. Yet, unlike the sun, these qualities disturb us, challenge us to non-indifference, and commands “responsivity”. These are the qualities of otherness that happen to us (see Francesetti in this volume), that we undergo in those extended moments of breathless silence that constitute the spaces between the inhaling and exhaling of being-with-the-other at the contact-boundary. These are commands to us clinicians, which both summon us and by the aesthetic qualities of their command, become the essence our clinical aesthetic relational knowledge (Spagnuolo Lobb 2018).

8. The field of the pathic

The pathic area seems very close to our notion of the contact-boundary. Even though atmospherology focuses on a spatial perspective and Gestalt therapy on a temporal one, the idea of an area-less space can be conceived as a kind of “temporalized space” (Alvim 2018, 76).

When the contact-boundary is considered from the point of view of the pathic, we can see it in terms of a field in which “pathos is an event, but an event of a special kind which happens to somebody” (Waldenfels 2011, 27).

All contact is contacting an other. Yet there are self-evident dissimilarities between contacting an object, a sensible being, and a human being in

Gestalt therapy terms. In general, contacting is referred to as the process of differentiating between “me” and a “not-me”. By contacting, I am able to determine differences, between this and that, between that and me. All contacting, of course, has its aesthetic qualities. I have an aesthetic sense of the sun on my face, a velvet cloth under my touch, the taste of food in my mouth. Yet there is another kind of contacting. It is contacting the human other. The aesthetic qualities of contacting a human other are of a different magnitude than contacting altogether. It is even of a different dimension. This is not a contacting that encounters difference, per se, but is a contacting that encounters the unyielding presence of the other as “alien”,¹³ whose very existence commands a response. This is a contacting that confounds contacting.

All contacting is a *disturbance* of an equilibrium since what is new surprises and becomes known. Contacting another person is *disruptive*, not of an equilibrium but of an order (Waldenfels 2011). It confronts us with a surplus which can never be entirely consumed... It tears open the net of sense, interrupts the system of rules, and thus decontextualizes the event. It is im-mediate because it breaks through mediations (Waldenfels 2011, 32).

This disruption puts mutuality out of question (Lévinas 1998). It is an aesthetic of passion that is alien to and overtakes the subject because the response to the alien other is prior to or at the root of our being subjects. It is at the timeless and spaceless “pre” of contacting itself. Our response happens as if to us before any sense of willing or action or intention, before any reflection, or thought. It is of the contact-boundary, yet of the contact-boundary disclosed in its most primordial, pre-subjective state.

¹³ “Alien” is a problematic word, which I use to be consistent with the English translations of the original used throughout the literature. Yet, in a correspondence with him, Waldenfels commented, “[...] for German speaking people the word *fremd* has special connotations. When Husserl started questioning the field of *Fremderfahrung* he did not only refer to regional questions of other persons, of the foreigner, of the stranger, but he described a certain quality of our experience. *Fremdheit*, cognate with the preposition “from”, means a certain distance, absence, deepness of experience, and *Fremdheit* originates from our own body, language, home or culture... In German we speak of *Fremdsprache*, *Fremdkörper*, *Fremdwelt*, *Fremdeln* of the little child, of *Entfremdung* or *Verfremdung*, and it may be difficult to find an English word which covers all these shades of sense and which respects the radical character of the alien. In my opinion it seems to be better to make use of an unusual word than to water down the phenomenon at stake. It is true, in many contexts we may speak of the ‘unfamiliar’, but what about the *Unheimlich*, the uncanny? I think we all should think and work by using the advantages of different languages” (Waldenfels, personal communication, October 22, 2018).

Under these conditions, contacting the human other is an *under-going*. The other overtakes us. The “I” become an accusative subject. It is here that it is possible to understand the power of Lévinas’s ethical subject erupting in response to the face of the other, or Waldenfels’s responsivity to the alien. We cannot be otherwise than non-indifferent in contacting the human other,¹⁴ which is the irrecusable activity of the relational function of self. And this is the basis for the “situated ethics of Gestalt therapy” (Bloom 2013). It is also the very condition for the possibility of therapeutic contacting. Insofar as the therapist is capable of undergoing the “whirlwind” (Roubal in this volume) emerging of the contact-boundary of the relational field, the therapist accepted this fundamental under-going of the otherness of the patient.

9. Conclusion

Things speak for themselves. Classical and contemporary phenomenology ring like bells throughout the clinical phenomenology of Gestalt therapy briefly described here. By considering Gestalt therapy from this perspective, I’ve indicated how its core ideas easily welcome compatible perspectives that can be integrated into our expanding theoretical and clinical horizons—without the core ideas being compromised. How and to what extent new perspectives can be integrated into or are even compatible with Gestalt therapy can only be determined through on-going critical exchanges among us. Good faith discourse requires engaging with concepts on their own terms. Each chapter in this book invites such dialogue.

I am left with a question. How did my own exploration of the horizons of Gestalt therapy’s phenomenology lead me on such a parallel track to those of the authors in this book—without my knowing a thing about the new-phenomenology? I suggest that I, they, and we are responding to a call from the larger world, a call to responsivity to a world of desensitization, to cruelty and to the rise of selfish autocracies.

Near the end of his essay, *Elimination of Metaphysics*, Rudolf Carnap writes,

metaphysics doesn’t describe states of affairs, but general attitudes of a person towards life... *[It] arises from the need to give expression to a man’s attitude to life, his emotional and volitional reaction to the*

¹⁴ Obviously, contacting the human other doesn’t always lead to these ecstatic epiphanies. Different modes or degrees of human contacting are described elsewhere (Bloom, 2016).

environment, to society, to the tasks to which he devotes himself, to the misfortunes that befall him (Carnap 1959, 78-79, emphasis added).

Despite Carnap's intention to discredit phenomenology (Heidegger's, most precisely), we can take this to heart as more of a compliment than a criticism. The approaches presented in this book arise from different points in the same world and reflect various styles of responsivity to the other. We know our work gives expression to felt, sensed, and known experiences of the very situations Carnap names. Our concepts enable our practical work as clinicians and, further, to engage with one another in the kind of professional conversation that expands our clinical understanding. Let Carnap keep his logical positivism and leave to us the therapeutic effectiveness of our clinical phenomenology.

References

- Alvim, Monica. forthcoming. "Sensing with the other: the pathic-aesthetical dimension of human experience." *Gestalt Review*.
- 2018. "Comment on Atmospheres and Pathic Aesthetics, by Tonino Griffero." In *The Aesthetic of Otherness, Meeting at the Boundary in a Desensitized World*, ed. by Margherita Spagnuolo Lobb, 75-78. Siracusa: Istituto di Gestalt HCC Italy Publ. Co.
- Bloom, Daniel J. 2003. "'Tiger! Tiger! Burning Bright'. Aesthetic Values as Clinical Values in Gestalt Therapy." In *Creative License: the Art of Gestalt Therapy*, eds. by Margherita Spagnuolo Lobb and Nancy Amendt-Lyon, 63-78. New York-Vienna: Springer.
- 2010. "The Phenomenological Method of Gestalt Therapy: Revisiting Husserl to Find the Essence of Gestalt Therapy." *Gestalt Review* 13, 2: 277-295.
- 2013. "Situated Ethics and the Ethical World of Gestalt Therapy." *Gestalt Therapy in Clinical Practice: from Psychopathology to the Aesthetics of Contact*, ed. by Gianni Francesetti, Michela Gecele and Jan Roubal, 131-145. Milan: Franco Angeli.
- 2016. "The Relational Function of Self." In *Self: A Polyphony of Contemporary Gestalt Therapists*, ed. by Jean-Marie Robine, 67-90. St Romain La Virvée: L'Exprimerie.
- 2019. "Gestalt Therapy and Phenomenology: when Parallel Lines Collide." In *Handbook for Theory, Research and Practice in Gestalt Therapy* (2nd edition), ed. by Philip Brownell. Newcastle upon Tyne: Cambridge Scholars Publishing.

- Forthcoming. "From Sapience to Sentience: the Awareness-consciousness Continuum and the Lifeworld." *Gestalt Review*.
- Carnap, Rudolph. 1959. "The Elimination of Metaphysics." In *Logical Positivism*, ed. by Alfred J. Ayer, 60-81. New York: The Free Press.
- Crocker, Sylvia. 2009. "Phenomenology in Husserl and Gestalt Therapy." *British Gestalt Journal* 18, 1: 18-28.
- Francesetti, Gianni, ed. 2015. *Absence Is the Bridge Between Us*. Gestalt Therapy Perspective on Depressive Experiences. Siracusa: Istituto di Gestalt HCC Italy Publishing Co.
- Francesetti, Gianni and Gecele, Michela. 2009. "A Gestalt Therapy Perspective on Psychopathology and Diagnosis." *British Gestalt Journal* 18(2): 5-20.
- Francesetti, Gianni, Gecele, Michela and Roubal, Jan, eds. 2013. *Gestalt Therapy in Clinical Practice: from Psychopathology to the Aesthetics of Contact*. Milano: Franco Angeli.
- Gurwitsch, Aron. 1970. "Problems of the life-World." In *Phenomenology and Social Reality. Essays in Memory of Alfred Schutz*, ed. by Maurice Natanson, 35-61. The Hague: Martinus Nijhoff.
- Husserl, Edmund. 1931. *Ideas. General Introduction to Pure Phenomenology* (1913). New York: MacMillan.
- 1970. *The Crisis of European Sciences and Transcendental Phenomenology* (1954). Evanston: Northwestern University Press.
- Lévinas, Emmanuel. 1998. *Otherwise than Being, or, Beyond Essence*. Pittsburgh: Duquesne University Press.
- Perls, Frederick, Hefferline, Ralph and Goodman, Paul. 1951. *Gestalt Therapy: Excitement and Growth in the Human Personality*. New York: Julian Press.
- Robine, Jean-Marie. 2014. "Contact, at the Source of Experience" (2011). In *The New York Institute for Gestalt Therapy in the 21st Century*, eds. by Dan Bloom and Brian O'Neill, 128-136. Peregian Beach: Ravenswood Press.
- 2018. "Aesthetic Relational Knowledge of the Field. A Revised Concept of Awareness in Gestalt Therapy and Contemporary Psychiatry." *Gestalt Review* 22, 1: 50-68.
- Steinbock, Anthony J. 1995. *Home and Beyond. Generative Phenomenology Beyond Husserl*. Evanston, IL: Northwestern University Press.
- Straus, Erwin. 2000. *Du sens des sens: Contribution à l'étude des fondements de la psychologie* (1935). Paris: Million.
- Waldenfels, Bernhard. 2003. "Lecture 2." In *Phenomenology Today: the Schuwer SPEP lectures 1998-2002*, eds. by Rudolf Berner and Daniel

- J. Martino, 23-59. Pittsburgh: Simon Silverman Phenomenology Center, Duquesne University.
- 2011. *Phenomenology of the Alien. Basic Concepts*. Evanston: Northwestern University Press.